

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B12*

CERTIFICATE OF DEATH

Reg. Dist. No.

12203
2160

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
805 Maple Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Wisconsin County _____
 City or town Milwaukee
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2431 W. McKinley St.
 (If rural, give LOCATION)
 2.(a) If veteran, name War _____

3. (a) FULL NAME

Hattie Baernstein

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Dan S. Baernstein
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 15, 1868
 8. AGE: Years 48 Months 5 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace San Francisco, Calif.
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER 12. Name Louis Enrich

13. Birthplace Germany

14. Maiden name Anna Koschke

15. Birthplace Germany

16. Informant Mr. Harry Baernstein

Address 4611 Highland Ave. Bethesda

17. Cremation Date thereof 12/30/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland

18. Funeral director Wm. Rucker Humphrey

Address Bethesda, Maryland

19. 12/28 1946 3pm E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1946, at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7 1946, to Dec. 26 1946 and that I last saw her alive on December 26 1946

Immediate cause of death Hypostatic pneumonia DURATION 4 days

Due to Cardio-vascular-renal disease 10 yrs. or more

Due to _____

Other conditions Progressive spinal muscular dystrophy about 2 yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Katharine A. Chapman M.D.
29 West Baltimore St. M. D. or other _____

Address Hennington, Md. Date signed 12/26/46

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W. J. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17920

CERTIFICATE OF DEATH

Reg. Dist. No. 122046

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....11 weeks
 Hospital, institution, or street address where death occurred:
home; 11, 114 Valley View Avenue
 How long in hospital or institution?.....11 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Mont
 City or town.....Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....11, 114 Valley View Avenue
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

BATES, Steven Lancaster

3. (b) Social Security Number

4. Sex.....male
 5. Color or race.....W-US
 6. (a) Single, married, widowed, or divorced.....single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....23 Sept. 1946
 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day.....
2.....22..... hrs. min.

9. Birthplace.....Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....Phillips L. Bates
 13. Birthplace.....Tenn.

MOTHER 14. Maiden name.....Legare Womble Bates
 15. Birthplace.....S.C.

16. Informant.....father: Phillips L. Bates

Address.....11, 114 Valley View Ave., Kensington, Md.

17. burial Date thereof.....12-16-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Orangeburg, S.C.
 Location.....

18. Funeral director.....W. W. Chambers
 Address.....1400 Chapin St., N. W., Wash., D.C.

19. 12-16.....46.....Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec 15..... 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1st med exam case..... 19..... to..... 19.....
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Aspirin sulph poisoning
accidental
 13 hrs. 45 min.

Due to.....

Due to.....

Other conditions.....

multiple congenital anomaly
especially of heart
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....accidental..... Date of 12-14-46

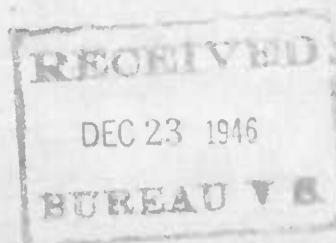
Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Frank J. Broschart..... M. D. or other

1st med exam
 Address.....Gaithersburg, Md...... Date signed.....12-16-46



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 820

CERTIFICATE OF DEATH

Reg. Dist. No. 12205 2230

1. PLACE OF DEATH

County..... Harford
 City or town..... Seamans Park
 (If outside city or town limits write RURAL and give nearest town)
 How long in above place of death?..... 3 1/2 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Donna Baurain

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Widowed
 6. (b) Name of husband or wife..... Emile Baurain

7. Birth date of deceased (mo., day, yr.)..... Oct 16 1864
 B. (c) If alive, give age..... years

8. AGE: Years..... 82 Months..... 2 Days..... 14
 If less than one day..... hrs. min.

9. Birthplace..... Casco, Me.
 (Town, county, and state)

10. Usual occupation..... Widow

11. Industry or business.....

12. Name..... Fanny Cochran13. Birthplace..... Belgium14. Maiden name..... unknown15. Birthplace..... Belgium16. Informant..... Most Rev. ParishAddress..... 11 Seaman Ave. Tahama Park17. Burial Date thereof..... Dec 31-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... Back River - Mich.18. Funeral director..... J. Arthur WalterAddress..... 254 Canal St. Baltimore19. 12/28 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12/28 19 46 at 12:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/28 19 46 to Dec 28 19 46and that I last saw him alive on 12/18 19 46

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

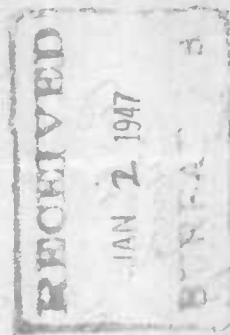
Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature..... Howard Thorne, M.D.Address..... 28 Carroll Ave. Tahama ParkDate signed..... 12/28/46



Released by Dr. Brischart. (Cormier)

Handwritten signature

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of mother's maiden name and the addition of date of birth is shown on G 108 1/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

12206

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County... Montgomery County Maryland
City or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery
City or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No... 9105 Fairview Road
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

John D Bland Jr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Julia F. Bland

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Nov. 20, 1874

8. AGE:

Years

Months

Days

If less than one day

72

0

10

hrs.

min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Civil Eng.

11. Industry or business

District Government

FATHER

12. Name

Edward Bland

MOTHER

13. Birthplace

King George Co. Virginia

14. Maiden name

Mary Frances NATHANIAL DAILY

15. Birthplace

IRELAND

16. Informant

Julia May Bland (Daughter)

Address

9105 Fairview Road

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

Dec 4, 1946
(month) (day) (year)

Cemetery or crematory

Mount Olivet

Location

Washington D.C.

18. Funeral director

The H.H. Hines Co

Address

2901 14th St N.W.

19. Dec 1

(Date rec'd by registrar)

1946

Josephine M Schaeff

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 1

1946

at

4:30

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar

1946

to

Dec 1

1946

and that I last saw him alive on

Nov 30

1946

Immediate cause of death

Coronary heart disease

DURATION

5 days

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Andrews Jr.

M.D. or other

Address

Silver Spring Md

Date signed

Dec 1-46

MARYLAND STATE DEPARTMENT OF HEALTH

2011 11, 1946

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DEPUTY CHIEF OF POLICE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DEPUTY SHERIFF

25. SIGNATURE OF JAILER

26. SIGNATURE OF WARDEN

27. SIGNATURE OF CHIEF OF POLICE

28. SIGNATURE OF DEPUTY CHIEF OF POLICE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF DEPUTY SHERIFF

31. SIGNATURE OF JAILER

32. SIGNATURE OF WARDEN

33. SIGNATURE OF CHIEF OF POLICE

34. SIGNATURE OF DEPUTY CHIEF OF POLICE

35. SIGNATURE OF SHERIFF

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SECRETARY

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12207

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

15 Sherman Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Sherman Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HENRIETTA BLOOM

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Simon Bloom

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1870

8. AGE: Years 76 Months 6 Days 14 If less than one day hrs. min.

9. Birthplace Nova Scotia
(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

FATHER 12. Name John Waters

13. Birthplace Ireland

MOTHER 14. Maiden name Anne Suffield

15. Birthplace Ireland

16. Informant Mrs. Ruth Boyle, daughter

Address 15 Sherman Ave., Takoma Park, Md.

17. Cremation Date thereof Dec. 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Suitland, Md.

18. Funeral director Waxner E. Pamphrey

Address 8434 Ga. Ave., Silver Spring, Md.

19. Dec. 30 19 46
(Date rec'd by registrar) Registrar J. H. Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 46 at 11:30 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 44 to Dec. 27 19 46

and that I last saw him alive on Dec. 26 19 46

Immediate cause of death Cardiac dilatation DURATION 1 day

Due to putral regurgitation 10 y.

Due to

Other conditions general debility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Shannon M.D.

M. D. or other

Address 113 Carroll St. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

Reg. Dist. No. 12208 2231

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since birth
 Hospital, institution, or street address where death occurred:
(Home) 700 Chaney Drive
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 700 Chaney Dr.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Cynthia Lynn Boatright.

3. (b) Social Security Number

4. Sex fe. 5. Color or race wh. 6.(a) Single, married, widowed, or divorced Baby
 6.(b) Name of husband or wife none
 7. Birth date of deceased (mo., day, yr.) may 13th 1946 6.(c) If alive, give age — years
 8. AGE: Years — Months 7 Days 14 It less than one day — hrs. — min.

8. Birthplace Takoma Park, Montgomery Co., Md.
 (Town, county, and state)

10. Usual occupation —11. Industry or business —

MOTHER FATHER
 12. Name Lucian Haynes Boatright.
 13. Birthplace Calhoun Ky.
 14. Maiden name Helen Louise Gossett.
 15. Birthplace Evansville, Ind.

16. Informant parents. 700 Chaney Dr
 Address Takoma Park, Md.

17. Burial Date thereof Dec 29, 1946.
 (Burial, cremation, or removal. Which) (month) (day) (year)
 Cemetery or crematory Big Marsh Memorial
 Location Big Road, Hyattsville, Md.

18. Funeral director —
 Address 251 Capital St., Takoma Park, D.C.

19. 12/27/46 18. 46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 46 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13th 19 46 to Dec 27 19 46.
 and that I last saw her alive on Dec 20 19 46.

Immediate cause of death dehydration due
to rupture of meningococci
on lower part of back. DURATION 10 days

Due to Also had bronchopneumonia 1 wk

Other conditions Hydrocephalus and birth

(Include pregnancy within 3 months of death)

Major findings of operations none
 Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

23. SIGNATURE Ruth Standord M.D.
 M. D. or other

Address 7906 Georgia Ave Date signed 12-27-46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526 X

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH: Montgomery
County 6409 Florida ST.
City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 YRS.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County MONTG.
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6409 Florida ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
EDMUND HEYWARD BOWLY

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Lucy Agnes Bowly
Deceased 6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) OCT. 15TH 1854
8. AGE: Years 92 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace N.Y. CITY
(Town, county, and state)
10. Usual occupation Retired

11. Industry or business
12. Name EDMUND BOWLY
13. Birthplace BALTIMORE Md.
14. Maiden name JANE HEYWARD
15. Birthplace SOUTH CAROLINA

16. Informant MR. LAWRENCE BOWLY
Address 6409 Florida ST. Ch. Ch. Md.
17. BURIAL Date thereof 12-30-46
(Burial, cremation, or removal - Which?) (month) (day) (year)
Cemetery or crematory ST. PETERS BOLIVAR
Location JEFFERSON Co. W. VA.

18. Funeral director Wm. Reuben Lumsden
Address Bethesda, Maryland
19. December 29, 46
(Date rec'd by registrar) Registrar Wm. E. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 December 1946 at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to 4:00 P.M. 12-28-46
and that I last saw him alive on Deceased on arrival
Immediate cause of death Carcinoma of urinary bladder DURATION 2 yrs.
Due to
Due to
Other conditions Acute Myocardial Infarction 5 minutes
Senility; Generalized arteriosclerosis Arter.
(Include pregnancy within 8 months of death)
Major findings at operations
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Shirley L. Lipp, M.D.
Address 3921 Ingomar St. Wash. D.C. Date signed 12-28-46

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

 12210
 Reg. Dist. No. 2170

1. PLACE OF DEATH:

 County Montgomery
 City or town Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Maryland County Montgomery

 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. R# 3 - Oakdale
 Loc. dec. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Britton

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

December 15, 1946

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace Olney, Montgomery County, Md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

 FATHER
 MOTHER

12. Name

George Britton

13. Birthplace

Kentucky

14. Maiden name

Mary Bowlin

15. Birthplace

Jonesville, Virginia

16. Informant

Hospital record

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec 17, 1946
(month) (day) (year)

Cemetery or crematory

Martins Farm

Location

Nx. Oakdale, Rockville, R.F.D.

16. Funeral director

George Britton & Father

Address

R#3 Rockville, Md

19.

(Date rec'd by registrar)

19. 46

Gertrude B. Lawler
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1946, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 15, 1946 to Dec. 17, 1946and that I last saw him alive on Dec. 17, 1946

Immediate cause of death

Prematurity

DURATION

6 1/2 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard A. Yates M.D.
M. D. or otherAddress Sandy Spring, Md Date signed 12/17/46

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BUREAU 8

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

12211

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County Montgomery

City or town Olney
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodfield - R. #1
(If rural, give LOCATION)

2(a) If veteran, name war 12

3. (a) FULL NAME

Mr. Albert Maurice Burdette

3. (b) Social Security Number

218-12-7833

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Mrs. Estelle Burdette

7. Birth date of deceased (mo., day, yr.) January 8, 1909 6. (c) Living, full age 35 years
December 26, 1946

8. AGE:

Years 37 Months 11 Days 18 If less than one day
hrs. min.

9. Birthplace Woodfield, Montgomery Co. Md.
(Town, county, and State)

10. Usual occupation Carpenter

11. Industry or business

12. Name John J. Burdette

13. Birthplace Maryland

14. Maiden name Cora King

15. Birthplace Woodfield, Maryland

16. Informant Hospital records

Address

Burial Date thereof Dec 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Grove

Location Woodfield

18. Funeral director W. W. Barker

Address Lafayetteville

19. Dec 26 19 46 Westfield, Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 19 46 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 19 46 to 19 46
and that I last saw him alive on 19 46

Immediate cause of death

Hemorrhage & shock

Due to shot gun wound in back

Rt. abdomen

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-25-46

Where did injury occur? Danvers Montgomery Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Trap shoot

Means of injury Shot gun Injured at work? no

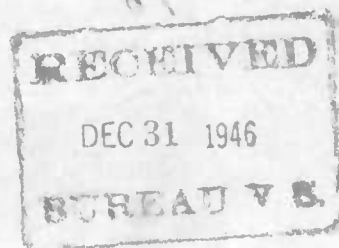
23. SIGNATURE Frank J. Bruchman M.D.
Dep med exam M. D. or other

Address Gaithersburg Md. Date signed 12-26-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-6)

CERTIFICATE OF DEATH

12212

Reg. Dist. No. 223

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>Takoma Park</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>5 months 19 days</u> Hospital, institution, or street address where death occurred: <u>Washington Sanitarium and Hospital</u> How long in hospital or institution? <u>5 months 19 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Silver Spring</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>105 Hilltop Road</u> (If rural, give LOCATION) 2. (a) If veteran, name war _____									
3. (a) FULL NAME <u>Burke, Mrs. Mary Eva</u>		3. (b) Social Security Number <u>Yes - Unknown</u>									
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>									
6. (b) Name of husband or wife <u>Thomas J. Burke</u>		6. (c) If alive, give age _____ years									
7. Birth date of deceased (mo., day, yr.) <u>Dec. 9 - 1892</u>											
8. AGE: <table border="1"><tr><td>Years</td><td>Months</td><td>Days</td><td>It less than one day</td></tr><tr><td><u>54</u></td><td><u>0</u></td><td><u>7</u></td><td><u>-</u> hrs. <u>-</u> min.</td></tr></table>	Years	Months	Days	It less than one day	<u>54</u>	<u>0</u>	<u>7</u>	<u>-</u> hrs. <u>-</u> min.			
Years	Months	Days	It less than one day								
<u>54</u>	<u>0</u>	<u>7</u>	<u>-</u> hrs. <u>-</u> min.								
9. Birthplace <u>Washington, D.C.</u> (Town, county, and state)											
10. Usual occupation <u>Housewife</u>											
11. Industry or business <u>Same</u>											
FATHER	12. Name <u>Edward Fleishall</u>										
	13. Birthplace <u>Washington, D.C.</u>										
MOTHER	14. Maiden name <u>Sarah Waltemeyer</u>										
	15. Birthplace <u>Washington, D.C.</u>										
16. Informant <u>Records - Washington Sanitarium and Hospital</u> Address <u>700 Carroll Avenue, Takoma Park, Maryland</u>											
17. Burial (Burial, cremation, or removal of remains) <u>Dec. 19, 1946</u> Date thereof (month) (day) (year) Cemetery or crematory <u>St. Philip's</u> Location <u>Wash. D.C.</u> Funeral director <u>Collins Funeral Home</u> Address <u>3821-14th St. N.W.</u> Date rec'd by registrar <u>Dec. 17, 1946</u> Registrar <u>John A. Doherty</u>											
20. DATE OF DEATH <u>December 16, 1946</u> at <u>7:40</u> p.m.											
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1-4-1942</u> to <u>12-16-1946</u> and that I last saw him alive on <u>12-16-1946</u>											
Immediate cause of death <u>Central Infarct multiple</u> Due to <u>central arteriosclerosis</u> <u>10 yrs.</u> Due to <u>generalized arteriosclerosis</u> <u>10 yrs.</u> Other conditions <u>chronic passive congestion of lungs</u> <u>3 yrs.</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results <u>as above</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. <u>2. VIOLENCE:</u> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? (City or town) (County) (State) _____ Injured at home, farm, industry, public place (where?) _____ Cause of injury _____ Injured at work? _____ 23. SIGNATURE <u>W. C. Shoemaker M.D.</u> <u>8005 Woodbury Drive</u> M. D. or other _____ Address _____ Date signed <u>12/12/46</u>											

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BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

215 Franklin Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harbor de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 S. Union Ave

(If rural, give LOCATION)

2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Margaret Busch

3. (b) Social Security Number

4. Sex F5. Color or race W

6. (a) Single, married, widowed, or divorced

Widowed8. (b) Name of husband or wife Henry Bernard Busch

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 21 May 18648. AGE: Years 82 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Patrick J. Bennett13. Birthplace Ireland14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs F. E. RudigerAddress 215 Franklin Ave, Silver Spring, Md17. Burial Date thereof Dec. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Baltimore, Maryland18. Funeral director Francis J. GallowayAddress 3821-14th St. N.W. Wash. D.C.19. Dec 25 19 46 Josephine in Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Dec 19 46 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 Dec 19 46, to 25 Dec 19 46and that I last saw him alive on _____ 19 _____Immediate cause of death Cerebral Hemorrhage

DURATION

1 hourDue to Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William D. Aud Md

M. D. or other

Address 9006 Colville Rd Date signed 25 Dec 46Silver Spring Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467 X

12214

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mos. 7 days
 Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
 How long in hospital or institution? 3 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County.....
 City or town... Washington, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 705 4th Street, NW
 (If rural, give LOCATION)
 2.(a) If veteran, name war... World War I

3. (a) FULL NAME

CAGEY, Vaughn Franklin

3. (b) Social Security Number

100 05 3033

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Edythe Gagey
 6. (c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) August 12, 1901
 8. AGE: Years 45 Months 3 Days 26 If less than one day hrs. min.

9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation Guard + Special Police
 11. Industry or business Civil Service
 12. Name Charlie Cagey
 13. Birthplace Penn.
 14. Maiden name Laura Ruse
 15. Birthplace Penn.

16. Informant Mrs. Edythe Gagey
 Address 705 4th Street, NW, Washinton, D. C.
 17. burial Date thereof 12-10-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.
 18. Funeral director W.W. Chambers
 Address 517 11th St. SE, Washington, D. C.
 19. 12-8 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec. 19 46 at 5:58A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 July 19 46 to 8 Dec. 19 46
 and that I last saw him alive on 8 Dec. 19 46
 Immediate cause of death.....

Carcinoma Pancreas

Due to.....

Due to.....

Other conditions Jaundicecachexia

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

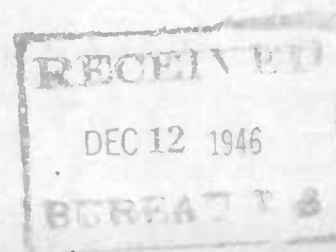
23. SIGNATURE.....
Frank S. ASHBURN, Comdr. (MC) USN
 M. D. or otherAddress USNH Bethesda, Md. Date signed 12-8-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/13/46



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1637

CERTIFICATE OF DEATH

12215

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs
 Hospital, institution, or street address where death occurred:
15 Prospect St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 15 Prospect St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph B. Chamberlain

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Anna Chamberlain
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) May 4 1863
 8. AGE: Years 83 Months 8 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Canton, N. H.
 (Town, county, and state)

10. Usual occupation novelty manufacturing

11. Industry or business

12. Name Jermicha Chamberlain

13. Birthplace N. H.

14. Maiden name Grace Burleigh

15. Birthplace N. H.

16. Informant Anna Chamberlain

Address 15 Prospect St. Kensington Md

17. Cremation Date thereof 1/4/47
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Lee's Crematorium

Location Wash. D.C.

18. Funeral director Wm. Lee's Sons Co

Address 300- 4th St N.E. Wash DC

19. Jan 4 1947 Josephine W. Schaffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam 1947 to 1947

and that I last saw him alive on case 1947

Immediate cause of death _____

Chloroform poisoning

Due to suicide

Due to _____

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1-4-47

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Frank J. Brosehart M.D.

Dep med Exam M. D. or other _____

Address Yantherburg Md Date signed 1-4-47

JAN 8 1947

BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

12216

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:Suburban Lodge

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. County D.C.City or town Wash. D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 2033
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clark William

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced W6. (b) Name of husband or wife Mary Alice Clark7. Birth date of deceased (mo., day, yr.) Dec. 13, 1888
8. (c) If alive, give age _____ years8. AGE: 58 Years 0 Months 0 Days 0 hrs. 0 min.9. Birthplace Belleme, Tenn.
(Town, county, and state)10. Usual occupation General Examiner11. Industry or business U.S. Govt.12. Name R. B. Clark13. Birthplace D.C.14. Maiden name Minerva Peeler15. Birthplace D.C.16. Informant Mary Alice ClarkAddress 2942 14th St. N.W.17. Burial Date thereof (month) (day) (year)Cemetery or crematory Rock Creek Cem.Location Wash. D.C.18. Funeral director The S. H. Hines Co.Address 2901 14th St. N.W.19. 12/5 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1946 19 46 at 5 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 32 to Dec. 5 19 46
and that I last saw him alive on Dec. 5 19 46Immediate cause of death Myocardial Infarction
DURATION 3 daysDue to Coronary artery disease 4.5 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature Charles R. Halsey, M.D.

23. SIGNATURE _____ M. D. or other

Address 1801 E. St. N.W. Date signed 3/2/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life insurance age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

12217

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
Crab Ave -
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Crab Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Daisy L. Clouser

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single married, widowed, or divorced Married
 6. (b) Name of husband or wife John W. Clouser
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 4 - 1897

8. AGE: Years 49 Months 2 Days 7 It less than one day _____ hrs. _____ min.

9. Birthplace Montgomery County - Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Samuel Lowe

13. Birthplace Montg. Co. Maryland

MOTHER 14. Maiden name Anne Margaret Bollan

15. Birthplace Montg. Co. Maryland

16. Informant John W. Clouser - husband

Address Crab Ave - Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec. 14 / 46
 (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Laitheburg - Maryland

18. Funeral director Wm. Reuben Pumphrey

Address Rockville - Maryland

19. 12-11-46 Boyd Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 19 46 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23 19 46 to Dec 11 19 46 and that I last saw her alive on Dec 10 19 46

Immediate cause of death Cerebral hemorrhage DURATION 7 days

Due to arteriosclerosis

Due to Hypertension 5 years

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, term, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Luthers, M.D. M. D. or other _____

Address Rockville, Md Date signed 12/11/46

RECEIVED

DEC 13 1946

BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

12218

Reg. Dist. No. 7160

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec 15, 1946

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 Old Georgetown Rd.How long in hospital or institution? Since Dec 13, 1946 - Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 5 East Living St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Grace B. Cooley

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced72 72 WhiteB.(b) Name of husband Maxwell S. Cooley

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1874

8. AGE: Years Months Days If less than one day

72 72 8 22 hrs. min.9. Birthplace Elmira New York
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Geo. W. Bopart13. Birthplace Staten Island - New York14. Maiden name Eleonora T. Couglan15. Birthplace Ireland16. Informant Capt. Geo. W. WalkerAddress Chevy Chase, Maryland17. Spigons Date thereof 12/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Elmira, New York18. Funeral director Wm Reuben ThompsonAddress Bethesda, Md.19. 13/17 46 Spigons
(Date rec'd by registrar) (year) (signature)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47 to December 17, 1946and that I last saw him alive on December 17, 1946Immediate cause of death Diabetes mellitus
and inter-tracheal arteric fracture 7 daysof right hip

Due to

Due to

Due to

Other conditions Generalized arteriosclerosis
and hypertension; hemorrhage
of right hip; chronic bronchitis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. generalized arteriosclerosis, atrophy of pancreas,
antony results: chronic pancreatitis, chronic bronchitis, chronic
hypertension, chronic hemorrhage of right hip

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of December 13, 1946Where did injury occur? Chevy Chase Montgomery Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury slipped Injured at work?23. SIGNATURE Richard V. Mattingly M.D.
M.D. or otherAddress 4707 Corn Lw. NW Wash DC Date signed

RECEIVED

DEC 23 1946

BUREAU OF

2-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

12219

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since Nov. 6, 1946
Hospital, institution, or street address where death occurred:
Suburban Hosp-8600 Old Georgetown Rd
How long in hospital or institution? since Nov. 6, 1946 Bethesda

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6000 New Hampshire Ave., N.W.
(If rural, give LOCATION)
If veteran, name war.

3. (a) FULL NAME

LOUISE K. DAVIS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife John P. Davis (Dec.)

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1876

8. AGE: Years 70 Months 2 Days 12 If less than one day hrs. min.

9. Birthplace Wilmington N. Carolina
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Richard Kostka

13. Birthplace

14. Maiden name Regina Salvi

15. Birthplace

18. Informant Hosp. Records

Address

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec. 6/46
(month) (day) (year)

Cemetary or crematory Loudon Cemetery

Location Baltimore Md.

18. Funeral director S. J. Lines Co.

Address 2901-14th St., N.W. D.C.

19. 12/1 19 46 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec 46 at 7:46 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Nov 46 to 4 Dec 46 and that I last saw him alive on 4 Dec 46

Immediate cause of death Accidental fall, causing DURATION
Gastric hemorrhage acute
recurrent, with anemia 5 da.

Due to gastric ulcer, two, sub- 2 mo +
acute

Pulmonary thrombosis 1 da.

Perforated peptic ulcer 28 da

Chronic pleurisy cardiovascular
(Include pregnancy within 3 months of death)
Perforated ulcer with hypertension

Major findings of operations Cholecystectomy Date of op. 13 Nov 46

Autopsy results given above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Nov 6, 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Accidental fall Injured at work?

23. SIGNATURE Wm E. Jones

Address 5522 WESTERN AVE. N.W. D.C.
1164 CHASE Date signed 4 Dec 46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

Reg. Dist. No. 12220 2230

1. PLACE OF DEATH:

County Montgomery
City or town 805 Maple Ave., Takoma Pk. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Jolliffe Nursing Home

How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 Turner Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Florence DeFontes

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Salatore Joseph DeFontes

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1875

8. AGE: Years 71 Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Henry Weil

13. Birthplace Maryland

14. Maiden name Mary A. Blach

15. Birthplace Baltimore, Maryland

16. Informant Frances A. DeFontes

Address 832 Jefferson St., N.W.

17. Burial Date thereof 12-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lincoln Cemetery

Location Maryland

18. Funeral director The S. W. Wines Company

Address 2901 - 14th St. N.W. Wash. D.C.

19. Dec. 19 19 46
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1946 19 46 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 26, to Dec 18 19 46
and that I last saw him alive on Dec 18 19 46

Immediate cause of death Cerebral Hemorrhage

DURATION

2 days

Due to Generalized Arteriosclerosis and hypertension

10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Richard V. Mattingly, M.D.
A. D. or other

Address 4707 Conn Ave N.W. Wash DC Date signed 12/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 21 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

12221

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 8:30 PM 12-6-46Hospital, institution, or street address where death occurred: Suburban Hosp
8600 Old Georgetown Rd - Bethesda Md.How long in hospital or institution? Since 8:30 PM 12-6-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town Washington DC
(If outside city or town limits, write RURAL and give nearest town)Street No. 4618 Wis Ave. N.W. Wash. D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

DE LUNG Austin BALLARD

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Kathleen DeLung

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) FEB 28 18708. AGE: Years Months Days If less than one day
76 yrs _____ hrs. _____ min.9. Birthplace Roanoke Virginia
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Franklin DeLung13. Birthplace Virginia14. Maiden name Mary Burnette15. Birthplace Virginia16. Informant Mrs A. P. WattsAddress 4618 Wisconsin Ave N.W. D.C.17. Burial Date thereof 12-8-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Lab Hill Ch Va.18. Funeral director H. H. Chambers CoAddress 3072-M ST Washington DC19. 12/7 46 Jm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 2:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to 12-7-46 and that I last saw him alive on 12-7-46

Immediate cause of death _____ DURATION

MyocarditisCongestive Heart FailureGeneralized atherosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. P. Andrews M.D.
M. D. or other _____Address 4201 Fessenden St N.W. Date signed 12-7-46

RECEIVED

DEC 10 1946

BUREAU

1-35

WATERSIDE 1406 R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

CERTIFICATE OF DEATH

Reg. Dist. No.

12222
2230

1. PLACE OF DEATH:

County Montgomery
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:

Washington San. HospitalHow long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Aspen St. N.W.
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Mrs. Effie E. Denmark

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mr. Clayton Denmarkdeceased 6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Oct. 16, 18898. AGE: Years 57 Months 3 Days 14 If less than one day hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation None11. Industry or business George W. Holloway12. Name George W. Holloway13. Birthplace Baltimore, Md.14. Maiden name Effie E. Fair15. Birthplace Frederick, Md.16. Informant Washington San. RecordsAddress 10701 Fair St. N.W.17. Removal Date thereof Nov. 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington D.C.Location The S. H. Davis Co.18. Funeral director The S. H. Davis Co.Address 2901-14th St. N.W. Wash. D.C.19. Dec 31, 1946 Registrar J. Edwin D. ...
(Date rec'd by registrar)

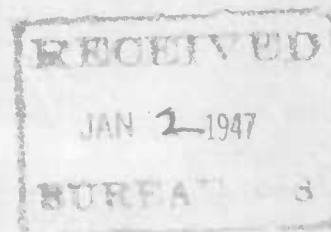
MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1946 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1946 to Dec. 30, 1946and that I last saw him alive on Dec. 20, 1946Immediate cause of death Myocardial infarctionarteriosclerotic stenosis, kidneyslong illness & atrophic arthritisDue to long illness & atrophic arthritisOther conditions invalid for 15 yrs, arthritismyocardial degeneration, pneumonia ofcoronary arteriesMajor findings of operations NoneDate of op. NoneAutopsy results As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of NoneWhere did injury occur? None (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Wm. A. Shannon M.D.Address 112 Carroll St. N.W. Date signed Dec. 30, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1479

CERTIFICATE OF DEATH

12223

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Mass. County _____
 City or town Somerville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 73 Fairfax St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war Naval

3. (a) FULL NAME

DENNEHY, Margaret Agnes

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 27 June 1914 6. (c) If alive, give age _____ years

8. AGE: Years 32 Months 5 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Mass.
 (Town, county, and state)

10. Usual occupation Navy

11. Industry or business _____

12. Name John Dennehy13. Birthplace Ireland dec.14. Maiden name Ellen Dennehy15. Birthplace Ireland16. Informant Mo: Mrs. Ellen DennehyAddress 73 Fairfax St., Somerville, Mass.17. burial Date thereof 12-12-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak GroveLocation Medford, Mass.18. Funeral director W. W. CHAMBERSAddress 1400 Chapin St., N. W. Wash., D.C.12-12 46 Mary Charlotte Smith19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1946 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam case and that I last saw him alive on _____

Immediate cause of death 1st, 2nd & 3rd degrees burns of about 80% of body
 Due to suicide

DURATION

12 hrs.

Due to _____

Other conditions Mental case

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 12-11-46Where did injury occur? Bethesda Mass MD
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) U.S. Naval Hosp.Means of injury burns Injured at work? no23. SIGNATURE Frank J. Bouchard M.D.Address Washington, Md Date signed 12-11-46

M. D. or other

RECEIVED

DEC 19 1946

BUREAU

2-25

2-2160 - 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

12224

CERTIFICATE OF DEATH

★ Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 1/2 hrs.
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hosp.
 How long in hospital or institution? 18 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Glenn Echo
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Wellesley Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Unnamed Baby Eiker #1

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white —

6. (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 26, 19468. AGE: Years Months Days If less than one day
18 hrs. 30 min.9. Birthplace Takoma Park, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name David Carlton Eiker13. Birthplace Washington, D.C.14. Maiden name Marquieite Blick15. Birthplace Washington, D.C.16. Informant Washington Sanitarium RecordsAddress Takoma Park, Md.17. Burial Date thereof Dec. 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Georgetown Park CemeteryLocation Hyattsville, Md.18. Funeral director J. Arthur WatersAddress 254 Carroll St. 2nd Floor19. Heard 19 46
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27- 19 46 at 11³⁰ a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-26- 19 46, to 12-27- 19 46
and that I last saw him alive on 12-27- 19 46Immediate cause of death Prematurity - bronchopneumonia

DURATION

Due to twin pregnancyDue to mother had high temp. on day of delivery - cause?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D.
M. D. or otherAddress Takoma Park, Md.Date signed 12-27-46

RECEIVED

DEC 30 1946

BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

12225
Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hrs
 Hospital, institution, or street address where death occurred:
Washington Sanitarium + Hospital
 How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Glenn Echols County Montgomery
 City or town Glenn Echols
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Wellesley Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Unname Baby Eiker

3. (b) Social Security Number

4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Baby
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 12-26-46 5⁰⁸ p.m.
 8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hrs. min.

9. Birthplace Washington Sanitarium + Hosp
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name David Carlton Eiker
 13. Birthplace Wash. D.C.
 14. Maiden name Marguerite Blitch
 15. Birthplace Wash. D.C.

16. Informant Record on Pt's chart
 Address Washington Sanitarium + Hosp

17. Buried Date thereof 12-27-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Geo Wash Mem Park Cem
 Location Bigg Rd. Md.

18. Funeral director Arthur Walter
 Address 26-4 Carroll St. Wash. DC
12-27-46 19. (Date rec'd by registrar) Arthur Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-1946 at 7⁰⁰ p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-26-1946 to 12-26-1946 and that I last saw him alive on 12-6-1946

Immediate cause of death

Prematurity - 6 mo gestation
wt - 1 lb. 7 1/2 oz
 Due to Twin pregnancy

Due to Mother had high temp before delivery - cause?
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Takoma Park, Md. Date signed 12-26-46

RECEIVED

DEC 28 1946

RECEIVED

1-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1170

CERTIFICATE OF DEATH

12226

Reg. Diat. No. 2161

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1939 Calvert St. NW.
(If rural, give LOCATION)
2. (a) If veteran, name war World War II

3. (a) FULL NAME

ETTER, Frank Jackson

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Hazel E. Etter 6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept. 9, 1915
8. AGE: Years 31 Months 2 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Painter
11. Industry or business Eberly's Washington, D.C.

12. Name James C. Etter
13. Birthplace Virginia
14. Maiden name Mary R. Hash
15. Birthplace Virginia

16. Informant Hazel E. Etter, wife
Address 1939 Calvert St. NW, Washington, D.C.
17. burial Date thereof 12-7-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery
Location Roanoke, Virginia
18. Funeral director W.W. Chambers Eff.
Address 1140 Chapin St., NW, Washington, DC

19. 7 Dec 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 December 19 46 at 10:30 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Nov. 19 46 to 7 Dec. 19 46
and that I last saw him im. alive on 7 Dec. 19 46
Immediate cause of death Hematoporphyria

DURATION 3 wks.
Due to unknown
Due to _____
Other conditions healed & active duodenal ulcer
Bronchopneumonia
(Include pregnancy within 3 months of death)
Major findings of operations negative
Autopsy results confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

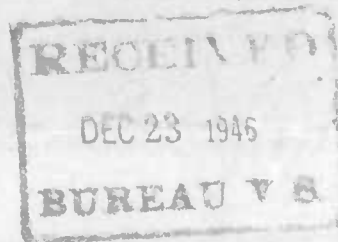
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE H. R. C. CHALMERS, Lt. Cdr. (MC) USN
M. D. or other _____
Address USNH Bethesda, Md. Date signed 12-7-46

MARGIN RESERVED FOR BINDING

9.45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-2160-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12569

Reg. Dist. No. 216

1. PLACE OF DEATH: County... <u>Montgomery</u> City or town... <u>Bethesda, (rural)</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>8 months, 13 days</u> Hospital, institution, or street address where death occurred: <u>US. Naval Hospital, Bethesda, Md.</u> How long in hospital or institution? <u>8 months, 13 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>D. C.</u> County _____ City or town... <u>Washington</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>2400 16th Street, N. W.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>Navy</u>			
3. (a) FULL NAME <u>FAIRFIELD, Arthur Philip</u> Vice Admiral USN Ret.Act.				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color or race <u>W-US</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
B. (b) Name of husband or wife <u>Nancy Fairfield</u>				20. DATE OF DEATH <u>14, December</u> 19. <u>46</u> , at <u>11:5A</u> M.			
7. Birth date of deceased (mo., day, yr.) <u>Oct. 29, 1877</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1 April</u> 19. <u>46</u> , to <u>14 Dec.</u> 19. <u>46</u> and that I last saw him alive on <u>14 Dec.</u> 19. <u>46</u>			
8. AGE: Years <u>69</u>		Months <u>1</u>		Days <u>15</u>		If less than one day _____ hrs. _____ min.	
9. Birthplace <u>Maine</u> (Town, county, and state)				MEDICAL CERTIFICATION			
10. Usual occupation <u>Navy</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>no</u> Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
11. Industry or business				Immediate cause of death <u>Myocardial Infarction</u>			
12. Name <u>R. A. Ablert</u> <u>dec.</u>				Due to <u>Coronary Artery Thrombosis</u>			
13. Birthplace <u>Maine</u>				Due to _____			
14. Maiden name <u>Frances Patton</u> <u>dec.</u>				Other conditions <u>Hypertension, azotemia and congestive heart failure</u> (Include pregnancy within 3 months of death)			
15. Birthplace <u>Maine</u>				Major findings of operations _____ Date of op. _____			
16. Informant <u>Wife: Nancy Fairfield</u>				Autopsy results <u>not performed</u>			
Address <u>2400 16th St. N.W. Washington, D.C.</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>Arlington National</u> <u>12-17-46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Arlington National</u> Location <u>Arlington, Virginia</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>no</u> Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____			
18. Funeral director <u>W.W. CHAMBERS</u> <u>C.R.O.</u>				23. SIGNATURE <u>Mary Charlotte Smith</u>			
Address <u>1400 Chapin St. N.W.</u>				US NH Bethesda, Md.			
19. <u>12-15-46</u> 19. _____ (Date rec'd by registrar)				Date signed <u>12-15-46</u>			

Registrar

RECEIVED

DEC 30 1946

BUREAU V S.

2-25

2-2160

2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12227

Reg. Dist. No.

2181

1. PLACE OF DEATH:
 County Montgomery
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Katie A. Fuick

3. (b) Social Security Number

1

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Robert J. Fuick
 6.(c) If alive, give age 28 years
 7. Birth date of deceased (mo., day, yr.) Dec 2 1885
 8. AGE: Years 61 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Middletown Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Hanson Rehler

13. Birthplace Middletown Md

14. Maiden name Sabine Doreus

15. Birthplace Middletown Md

16. Informant Robert J. Fuick

Address Fairview Rd

17. Burial Date thereof Dec 6 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Lukes Redland

Location Montgomery Co Md

18. Funeral director Ref W Barber

Address Leontownville Md

19. 1/10/46 19 _____
 (Initialed by registrar) Registrar R D Bell

12 MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4/1946 1946, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946, to Dec 3 1946, and that I last saw her alive on 12/11 1946.

Immediate cause of death acute cardiac dilatation

DURATION

3 days

Due to Chronic Myocarditis 6 mos

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____

Address Sandy Spring Md Date signed 12/5/46



2-2180-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 333

CERTIFICATE OF DEATH

Reg. Dist. No. 1223880

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 hours
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Darnestown
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Julian Griffith

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 20, 1873 6. (c) If alive, give age _____ years

8. AGE: Years 73 Months 7 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Darnestown, Montgomery, Maryland
 (Town, county, and state)

10. Usual occupation Retired Government Employee

11. Industry or business

12. Name Julian Griffith
 13. Birthplace Montgomery, Maryland

14. Maiden name Mary V. Harper
 15. Birthplace Montgomery Co. Maryland

16. Informant Mrs. Clyde Griffith
 Address Gaithersburg, Md. R.F.D.

17. Burial Date thereof 12-29-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Darnestown Cemetery

Location Darnestown, Md.

18. Funeral director E. C. Gartner

Address Gaithersburg, Md.

19. Dec 29 1946 Alfred J. Grier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1946, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on
Dec. 26 1946, to _____ 1946

and that I last saw him alive on Dec. 26, 1946 at 5 P.M.

Immediate cause of death was Broncho-
pneumonia (Secondary to
influenza).

Due to _____

Due to _____

Other conditions marked debility
of respiratory center
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wilton D. House M.D.

Address Darnestown Md. Date signed Dec 28/46

RECEIVED
DEC 31 1946
BUREAU V B

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

CERTIFICATE OF DEATH

Reg. Diat. No. 12229 2430

1. PLACE OF DEATH:

County Montgomery
 City or town Tadoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
801 Greenwood Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County Montgomery
 City or town Tadoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 801 Greenwood Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Grace Moore Guilford

3.(b) Social Security Number

4. Sex Fe 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife James W. Guilford
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 1, 1968
 8. AGE: Years 78 Months 6 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Hastings, Barry County, Michigan
 (Town, county, and state)
 10. Usual occupation Secretary
 11. Industry or business

MOTHER FATHER
 12. Name Levi G. Moore
 13. Birthplace Walled Lake, Michigan
 14. Maiden name Alie Bands Moore
 15. Birthplace Ada, Michigan

16. Informant (Daughter) Maude Guilford Wood
 Address 801 Greenwood Ave. Tadoma Park, MD.

17. Burial Date thereof Dec. 7, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt. Hope Cemetery
 Location Lansing, Mich.

16. Funeral director James Stallers
 Address 254 Carroll St. Takoma Park, D.C.

19. Dec. 6, 1946 (Date rec'd by registrar) Registrar St. Michaels

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1946 at 12:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to 12/5 1946
 and that I last saw her alive on 12/5 1946

Immediate cause of death Branchio-pneumonia DURATION 5 days

Due to _____
 Due to _____

Other conditions Hypertension
Cardio-vascular renal disease
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work?

23. SIGNATURE Benjamin M.D. M. D. or other
 Address Bethesda, Md. Date signed 12/5/46

RECEIVED

DEC 10 1946

BUREAU V &

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12230

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 38 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Leeward Green
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME
HADDOCK, John Alfred,

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Mable Haddock

7. Birth date of deceased (mo., day, yr.) 11 June 1898 6. (c) If alive, give age _____ years

8. AGE: Years 48 Months 6 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Crafterman, Navy Dept.

11. Industry or business

12. Name Mr. John Haddock

13. Birthplace Pa.

14. Maiden name Wade Cunningham

15. Birthplace Pa. dec.

16. Informant wife: Mrs. John Haddock

Address 9 Leeward Green, Wash., D.C.

17. burial Date thereof 12-23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W.W. Chambers, - R. Burns

Address 1400 Chapin St., N.W., Wash., D.C.

19. 12-20 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec. 19 46 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 Nov. 19 46 to 20 Dec. 19 46

and that I last saw him alive on 20 Dec. 19 46

Immediate cause of death Mesenteric embolism and broncho pneumonia

Due to pericardial thrombosis

Due to acute fib. due to

myocardial infarction due to

chronic heart disease

Other condition Cerebral embolus

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

C. W. THOMPSON, Lt. Cdr. (MC) USNR

23. SIGNATURE _____ M. D. or other _____

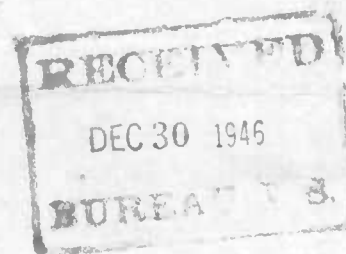
Address USNH Bethesda, Md. Date signed 12-20-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

12/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-2160

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No.

1223140

1. PLACE OF DEATH:

County MONTGOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 YRS

Hospital, institution, or street address where death occurred:

7 NORMANDY DRIVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

Country MONTGOMERY STATE MARYLAND
State MONTGOMERY County SILVER SPRINGCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 NORMANDY DRIVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CARRIE J. HAYDEN

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

DIVORCED

6.(b) Name of husband or wife CHARLES6.(c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) 4 JAN. 18988. AGE: Years 48 Months 11 Days If less than one day hrs. min.9. Birthplace FEDERALBURG MARYLAND
(Town, county, and state)10. Usual occupation CHERK11. Industry or business GENERAL ELECTRIC CO.12. Name JOHN FUNR13. Birthplace MARYLAND14. Maiden name MARY O'DAY15. Birthplace MARYLAND16. Informant HAROLD R. BECKLEYAddress # 7 NORMANDY DRIVE, SS, MD.17. Burial Date thereof 12-14-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FORT LINCOLNLocation Prince Georges Co.16. Funeral director W.W. Chambers Co.Address 1400 Chapin St. N.W.19. Dec 12 19 46 Josephine W. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 12 DECEMBER 1946 at 3:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 MAY 19 46 to 12 DEC. 19 46and that I last saw h.e.r. alive on 11 DEC. 19 46Immediate cause of death VENTRICULAR FIB-ILLATION, CONGESTIVEHEART FAILUREDue to RHEUMATIC MYO-ANDENDOCARDITISDue to RHEUMATIC FEVER

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marshall Leveille Jr. MD

M.D. or other

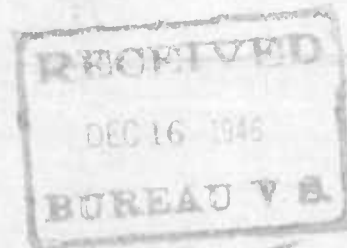
Address 8648 GEORGIA AVE. Date signed 12 DEC. 46

SILVER SPRING, MD.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

12232

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County Montgomery
 City or town Rural - Md. Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
R.F.D. Rockville
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Rural - Md. Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. Rockville
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edward Ariel Howell

3. (b) Social Security Number

577-30-1476

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Virginia U. Howell
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) October 7-1872
 8. AGE: Years 74 Months 2 Days 2 If less than one day
hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1946 at 3:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 1945 to Dec. 9, 1946
 and that I last saw him alive on December 8, 1946
 Immediate cause of death congestive heart failure
 Due to chronic valvular heart disease
 Due to several years
 DURATION 2 days
 Other conditions
 (Include pregnancy within 8 months of death)

9. Birthplace Fairfield - Iowa
 (Town, county, and state)
 10. Usual occupation Retired - U. S. Postal Employee
 11. Industry or business
 FATHER 12. Name George Howell
 13. Birthplace Fairfield - Iowa
 MOTHER 14. Maiden name Katherine Mount
 15. Birthplace Fairfield Iowa
 16. Informant Mrs. Virginia Howell
 Address R.F.D. Rockville - Md
 17. Burial Date thereof Dec 12/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Sedan Hill Cem
 Location Bethesda - Maryland
 18. Funeral director Wm. Arthur Dempsey
 Address Rockville - Maryland
 19. 12-10 19 46
 (Date rec'd by registrar) per Dr. M. D.

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE G. J. Hartley M.D.
 Address Rockville, Md Date signed 12/10/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1946

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1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B30

CERTIFICATE OF DEATH

12233

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? _____
Hospital, institution, or street address where death occurred: Bellevue Hospital
How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Cabin John
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3rd St.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME

O'Beulah Carol Hunter

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Richard
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) December 31, 1892
8. AGE: Years 54 Months 10 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace Montgomery, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William McCosson

13. Birthplace Bethesda

14. Maiden name Victoria Case

15. Birthplace Bethesda

16. Informant Richard E. Hunter

Address Cabin John, Maryland

17. Burial Dec. 29, 1946

(Burial, cremation, or removal. Which?) Date the act (month) (day) (year)

Cemetery or crematory Potomac Church Cemetery

Location Maryland

18. Funeral director Wm. Reuben Humphrey

Address Bethesda, Maryland

19. 12/28 19 46 Wm E. Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 19 46 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 38 to Dec 19 46

and that I last saw him alive on Dec 25 19 46

Immediate cause of death Coronary Artery Disease

Due to Hypertension

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm E. Jones

Address Asst. Dir. Health Dept. Date signed 12/28/46

M. D. or other _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

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2-35-

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12580

Reg. Diat. No. 2161

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hours
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 13 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4803 Hampton Lane
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
IVEY, Ralf Julian

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Iva Ivey

7. Birth date of deceased (mo., day, yr.) 7-29-92 8. (c) If alive, give age years

8. AGE: Years 54 Months 4 Days 28 If less than one day hrs. min.

9. Birthplace Fla.
(Town, county, and state)

10. Usual occupation Pharm. People's Drug Store

11. Industry or business

12. Name Robert A. Ivey
13. Birthplace Fla. (dec.)

14. Maiden name Elizabeth Daracutt
15. Birthplace Fla. (dec)

18. Informant Wife: Mrs. Iva Ivey
Address 4803 Hampton Lane, Bethesda, Md.

17. removal Date thereof 12-27-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Lake City, Fla.

18. Funeral director W. W. CHAMBERS
Address Georgetown, D. C.

19. 12-27 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec. 19 46 at 9: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Dec. 19 46 to 27 Dec. 19 46
and that I last saw him alive on 27 Dec. 19 46

Immediate cause of death Pneumonia DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results yes as above Date of op.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE O. R. S. Smith, Comdr. (MC) USN
M. D. or other

Address USNH Bethesda, Md. Date signed 12-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

178/97

RECEIVED

JAN 10 1947

BUREAU OF

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 446 X

CERTIFICATE OF DEATH

12234

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Dec. 18, 1946

Hospital, institution, or street address where death occurred:

Suburban Hosp. - 8600 Old Georgetown RdHow long in hospital or institution? Since Dec. 18, Bethesda

3. (a) FULL NAME

Mrs Bell S. Joyner

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Walker W. Joyner (Dec)

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Feb. 6, 1880

8. AGE:

Years

Months

Days

If less than one day

66105

hrs.

min.

9. Birthplace

Accomac Virginia

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

Geo. Thomas Scarborough

13. Birthplace

Accomac Virginia

MOTHER

14. Maiden name

Henrietta E. Blackstone

15. Birthplace

Accomac Virginia

16. Informant

Mrs. Edward E. Mullin

Address

45 Fawcett St. Kensington, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/23/46

Cemetery or crematory

Arlington Natl. Cem

Location

Arlington Virginia

18. Funeral director

Wm Reuben Humphrey

Address

7557 Wis. Ave. Bethesda, Md19. 12/234619. gpc E Jones19. gpc E Jones19. gpc E Jones19. gpc E Jones19. gpc E Jones19. gpc E Jones19. gpc E Jones19. gpc E Jones

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montg

City or town

Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

45 Fawcett St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 19 46 at 3:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 19 46 to Dec 21 19 46and that I last saw him alive on Dec 21 19 46

Immediate cause of death

Carcinoma of uterus

DURATION

1 yr.

Due to

Due to

Other conditions

Intraoperative hemorrhage

(Include pregnancy within 3 months of death)

1 day

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. J. Bowerspeed M.D.

M. D. or other

Address

Bethesda MdDate signed 12/22/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

BURFAT 18

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

12235

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred: 708 SLIGO AVE
Joeliffenurse Home SILVER SPRING
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8404-Ramsey Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Annie Millington Kauffmann

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William Peter Kauffmann

6. (c) If alive, give age

deceased

7. Birth date of deceased (mo., day, yr.)

September 8, 1868

8. AGE:

Years

Months

Days

If less than one day

78225

hrs.

min.

9. Birthplace

Darby, England.

(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

Home

MOTHER FATHER

12. Name

Henry Oldrow Millington

13. Birthplace

Darby, England.

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Son: Maj. William Peter Kauffmann.

Address

8404-Ramsey Ave, Silver Spring, Md.

17. Shipment + burial

Dec 5, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Sauwel Cemetery

Location

Port Jervis, Orange Co., N.Y.

18. Funeral director

Warner E. Pumphrey

Address

Silver Spring, Md.

19. Dec 4

Dec 4

(Date rec'd by registrar)

1946

Josephine M. Khaffer

Register

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946 at 7:30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1, 1946 to December 3, 1946 and that I last saw him alive on December 3, 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to

Hypertension arterial7 years

Due to

Fracture left femur4 days

Other conditions

Fracture left femur4 days

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 11/29/46Where did injury occur? Silver Spring, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall in room Injured at work? no

23. SIGNATURE

Frank E. Bacon M.D.

M. D. or other

Address 62-Knowles Ave, Kensington, Md. Date signed Dec 3, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1946

BUREAU V S

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46d)

CERTIFICATE OF DEATH

12236

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 1 day
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 2 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Albany
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1904 Fairfax Road
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME

KING, Guy Bryan

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Elizabeth King

7. Birth date of deceased (mo., day, yr.) July 15, 1896

8. AGE: Years 50 Months 5 Days 4 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Benjamin King (dec.)

13. Birthplace Maryland

14. Maiden name Rose Brown

15. Birthplace Maryland

16. Informant Mrs. Elizabeth King

Address 1904 Fairfax Rd, Annapolis, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 12-21-46
(month) (day) (year)

Cemetery or crematory

Location Annapolis, Md.

18. Funeral director Ben F. Happing 1327

Address 207 West St. Annapolis, Md.

19. (Date rec'd by registrar) 12-19-46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 December 19 46 at 7:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Oct. 19 46 to 19 Dec. 19 46

and that I last saw him alive on 19 Dec. 19 46

Immediate cause of death Carcinoma of Rectum DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ronald Grant MD

Address USNH Hospital Bethesda Md. Date signed 12-20-46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M 2

12/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

BUREAU 78

2-25

2-2160 ——— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

12237

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County..... Montg Co,
City or town..... Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 15 yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Md County..... Montg
City or town..... Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Alice Arlene Kinsey

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widow

Granvil Kinsey

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... July 9th 1881 6.(c) If alive, give age..... years

8. AGE: Years..... 65 Months..... 5 Days..... 29 If less than one day..... hrs. min.

9. Birthplace..... Damascus Md,
(Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business.....

FATHER 12. Name..... Milton Boyer

13. Birthplace..... Md

MOTHER 14. Maiden name..... Elizabeth Purdum

15. Birthplace..... Md

16. Informant..... Edwin Kinsey

Address..... Gaithersburg Md

Burial..... 12/10/46

17. (Burial, cremation, or removal. Which?)..... Date thereof..... (month) (day) (year)

Cemetery or crematory..... Damascus Cemetery

Location..... Damascus Md,

Ernest C Gartner

18. Funeral director.....

Address..... Gaithersburg Md

19. Dec 9 1946 Abunda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 8th 1946 at 2 30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1946 to Dec 8 1946

and that I last saw her alive on Dec 8 1946

Immediate cause of death..... Chronic nephritis DURATION over 10 yrs

Due to..... Arteriosclerosis over 10 yrs

Due to..... Senility

Other conditions..... Diabetes mellitus over 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Geo. D. Kelly, M.D.

Address..... Dawsonville, Md.

Date signed..... 8 Dec 46

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DEC 12 1946

BURFORD

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

12238

Reg. Dist. No.

2160

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hosp., 8600 Old Georgetown Rd.

How long in hospital or institution?

Bethesda

3. (a) FULL NAME

Mrs Beatrice Kokalis

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Paul Kokalis

7. Birth date of deceased (mo., day, yr.)

Ugentini 14/mo/1889

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

??5715

hrs.

min.

9. Birthplace

Sparta Greece

(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

FATHER

12. Name

Venach

13. Birthplace

Greece

MOTHER

14. Maiden name

15. Birthplace

Greece

16. Informant

Charles R. L. Hally MD

Address

1801 Eye ST. N.W.

17.

(Burial, cremation, or removal. Which?)

Removal

Date thereof

Dec 19-1946
(month) (day) (year)

Cemetery or crematory

Location

Washington DC

18. Funeral director

Chambers CO

Address

Washington, DC

19.

(Date rec'd by registrar)

19

462pmE Jones

Registrar

Address

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington DC
(If outside city or town limits, write RURAL and give nearest town)

Street No.

4300 S Dakota Ave, N.E.

(If rural, give LOCATION)

2. (a) If veteran, name War

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 19 1946 at 7 51 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/mo/1943 19... to 19/Dec/1946

and that I last saw him

alive on... 19...

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

? Hours

Due to

HYPERTENSIVE CARDIO-VAS-

Due to

CULAR DISEASE? YEARS

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

HEAD NOT DONE - ENLARGED HEART

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles R. L. Hally MD

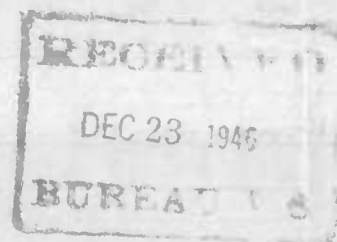
M. D. or

Address

1801 Eye ST N.W.

Date signed

19/Dec/46



1-35

CERTIFICATE OF DEATH

12239
Reg. Dist. No. 2, 80

VS A15

d
23. SIGNATURE..... L.D. Hayter, M.D.
M. D. or other
Address..... Rockville, Md. Date signed..... 12/26/44

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
DEC 28 1946
BUREAU OF

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-2

CERTIFICATE OF DEATH

12240 2160
Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 min.
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY
 City or town KENSINGTON
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4311 Clearbrook Lane
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

LOUISE SAHLI HOUELESS

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

SAMUEL B. HOUELESS

6. (c) If alive, give age

60 years

7. Birth date of

deceased (mo., day, yr.) Oct 12 1927

8. AGE:

59 Years 1 Months 36 Days If less than one day

hrs. min.

9. Birthplace Monroe Co Ohio
(Town, county, and state)10. Usual occupation HOME MAKER

11. Industry or business

12. Name OTTO SAHLI13. Birthplace Switzerland14. Maiden name Emma Witsch15. Birthplace Switzerland16. Informant HusbandAddress 4311 Clearbrook Lane Kensington Md17. BURIAL Date thereof 12/11/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Prospect Hill CemLocation WASHINGTON, D.C.18. Funeral director Joseph F. Birch's SonAddress 3034 - An St. N.W. Wash. D.C.19. 12/8 19 46 9pm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 46 at 5:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/8/46 to 12/8/46and that I last saw him alive on 12/8/46

Immediate cause of death

Cerebral hemorrhageDue to hypertensionDue to 2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brumhart M.D.Address Washington Md Date signed 12/8/46

RECEIVED

DEC 12 1946

BUREAU VS

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

CERTIFICATE OF DEATH

Reg. Dist. No. 12241 7140

1. PLACE OF DEATH:

County MontgomeryCity or town Birmingham
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Birmingham
(If outside city or town limits, write RURAL and give nearest town)Street No. 9632 Birmingham Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Lena May Luxen

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband Harry Luxen7. Birth date of deceased (mo., day, yr.) Sept. 15th 1884 8.(c) If alive, give age _____ years8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Missouri
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Harry M. Danison13. Birthplace Ind.14. Maiden name Ida Mattingly15. Birthplace Mo.16. Informant Mr. C Ray DanisonAddress 9632 Birmingham Parkway, Birmingham 72017. Rural (Burial, cremation, or removal, which?) Date thereof Dec. 3, 1946
(month) (day) (year)

Cemetery or crematory

Location Gilman City, Missouri18. Funeral director Cherry Chase Funeral HomeAddress 5103 Wisconsin Ave. N.W. Wash. D.C.19. Dec 1 19 46 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1946 at 2⁰⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1942 to December 1, 1946and that I last saw her alive on December 1, 1946Immediate cause of death Congestive Heart FailureDue to Arterio SclerosisDue to Rheumatic Fever

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert D. Farrell M.D.Address 5516 Nebraska Ave. DC. Date signed 11/1/46

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1946-12-03

RECEIVED
DEC 3 1946
BUREAU 78

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

12242

Reg. Dist. No. 4430

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2006 Columbia Rd. NW
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mack, Mr. Sidney John

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. Martina Mack
 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1883

8. AGE: Years 63 Months 3 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Lackawanna Co., Penna.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business _____

12. Name John Mack13. Birthplace Penna.14. Maiden name ?15. Birthplace Penna.16. Informant Washington Sanitarium and Hosp.Address Takoma Park, Md.17. Burial Date thereof Dec. 19-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington County, Va.18. Funeral director S. H. HINES CO.Address 2901-14th St. N. W.19. Dec 16 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 19 46, at 2:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 19 46 to Dec 16 19 46
 and that I last saw him alive on Dec 15 19 46

Immediate cause of death Coronary Arterial Failure DURATION Terminal

Due to AtherosclerosisDue to HypertensionOther conditions Diabetes Mellitus Cerebral Hemorrhage 13 yrs
(Include pregnancy within 5 months of death) 17 days

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert H. Hines M. D. or other _____Address Takoma Park, Md. Date signed 12/16/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

12243

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 1 day
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 2 mos. 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.Y. County New York
City or town New York
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 West 109th St.
(If rural, give LOCATION)
World War II
2. (a) If veteran, name war World War II

3. (a) FULL NAME

MALLOY, Francis Xavier

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife single
6. (c) If alive, give age single years

7. Birth date of deceased (mo., day, yr.) October 27, 1894

8. AGE: Years 52 Months 1 Days 16 It less than one day hrs. min.

8. Birthplace New York, New York
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Joseph Malloy

13. Birthplace New York

14. Maiden name Margaret Costello

15. Birthplace New York

16. Informant Sister: Miss Anna Malloy

Address 201 West 109th St., N.Y., N.Y.

17. Burial Burial Date thereof 12-15-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Calvary Cemetery

Location New York, New York

18. Funeral director W.W. Chambers

Address 1400 Chapin St. NW, Washington, D.C.

19. 12-15 16 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 December 19 46 at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 19 46 to Dec. 14 19 46
and that I last saw him alive on 14 Dec. 19 46

Immediate cause of death Cosineum Stomach DURATION 6 mos

Due to Cosineum Stomach

Due to Cosineum Stomach

Other condition Cosineum Stomach

(Include pregnancy within 3 months of death)

Major findings of operations Cosineum Stomach

Date of op. Cosineum Stomach

Autopsy results Cosineum Stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Cosineum Stomach Date of Cosineum Stomach

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Cosineum Stomach

Manner of injury Cosineum Stomach Injured at work? Cosineum Stomach

23. SIGNATURE Frank S. ASHBURN, Lt. Cdr. (MC) USN

M. D. or other Frank S. ASHBURN, Lt. Cdr. (MC) USN

Address USNH Bethesda, Md. Date signed 12-15-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/22/46

RECEIVED

DEC 30 1946

BUREAU V S.

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12244

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 821 H St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

MALTMAN Joseph Franklin

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 28, 1886

8. AGE: Years 60 Months 2 Days 9 If less than one day hrs. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name Steward Maltman

13. Birthplace Ireland

14. Maiden name Emily Whiteman

15. Birthplace Ireland

16. Informant daughter: Mrs. Marie R. Schlicht

Address 821 H St., N. E., Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) 12-10-46
(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director Timothy Hanlon Funeral Home T. J. H.

Address 641 H St. NE, Wash., D. C.

19. 12-7- 46 Mary Charlotte Smith
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 December 19 46 at 11:50AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 19 46 to Dec. 7 19 46
and that I last saw him alive on 7 Dec. 19 46

Immediate cause of death Thrombosis coronary artery
Due to Coronary artery sclerosis
Due to Generalized arteriosclerosis
chronic nephritis +
Other conditions hypertension
(Include pregnancy within 3 months of death)

Major findings of operations same Date of op.

Autopsy results same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide same Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury CW Thompson Injured at work?

23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USNR
M. D. or other

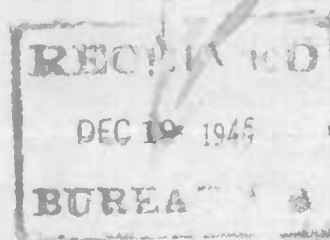
Address USNH Bethesda, Md. Date signed 12-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/13/46



2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

CERTIFICATE OF DEATH

Reg. Dist. No. ~~12243~~ 140

1. PLACE OF DEATH:

County Montgomery
City or town Burtonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Burtonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Florence Edna McAllister

3. (b) Social Security Number

44-1-10000

4. Sex FEMALE 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Edgar Ordie McAllister
7. Birth date of deceased (mo., day, yr.) May 17, 1917 8. (c) If alive, give age _____ years
8. AGE: Years 29 Months 6 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Burtonsville, Md.
(Town, county, and state)

10. Usual occupation Radio Technician in the

11. Industry or business Airplane Factory at River

12. Name Benjamin Franklin McAllister, Jr.

13. Birthplace Burtonsville, Md.

14. Maiden name Mary Elizabeth Merson

15. Birthplace Burtonsville, Md.

16. Informant Mrs. Harriet McAllister

Address Burtonsville, Md.

17. Burial Date thereof Dec 13, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Union

Location Burtonsville, Md.

18. Funeral director Wm. J. Donahoe

Address Home, Md.

19. Dec 13 1946 Josephine Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1946, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med exam case to 19 and that I last saw him alive on 19

Immediate cause of death Increased hemorrhage due to fracture of skull
Due to _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____
Autopsy results same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide homicide Date of 12-10-46

Where did injury occur? Burtonsville, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury hammer Injured at work?

23. SIGNATURE Frank J. Bronckart M.D.
Sept med Exam M. D. or other

Address Yarpsburg, Md. Date signed 12-10-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 16 1946
BUREAU V.B.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12246

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. 126 East Wilson Road.
(If rural, give LOCATION)
2(a) If veteran, name war ✓

3. (a) FULL NAME

Mc MILLAN, Louise Marie

3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Milo D. McMillan

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1919 6. (c) If alive, give age _____ years

8. AGE: Years 27 Months 0 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Elias DeSylva

13. Birthplace Mass. (dec)

14. Maiden name Bessie Dickson

15. Birthplace Scotland

16. Informant husband: Milo D. McMillan

Address 126 E. Wilson St., Indian Head, Md.

17. Burial Date thereof 12-16-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director W.W. Chambers

Address 1400 Chapin St. NW, Wash. D.C.

12-14 46 Mary Charlotte Smith

19. (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Dec. 19 46 at 10:12a

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9 Dec. 19 46 to 13 Dec. 19 46

and that I last saw him alive on 13 Dec. 19 46

Immediate cause of death congestive heart failure DURATION

Due to Valvular Rheumatic heart disease mitral stenosis & insuff

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results advanced mitral stenosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury T.S. Barnes Injured at work? _____

C. T. S. BARNES, Lt. Cdr. (MC) USN

23. SIGNATURE _____ M. D. or other _____

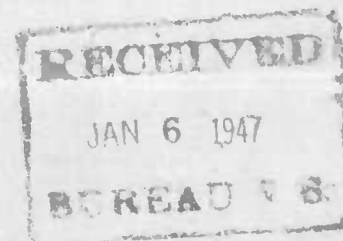
Address USNH Bethesda, Md. Date signed 12-14-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

11/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

12570
★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5730 1st St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war 1st World War

3. (a) FULL NAME

McWILLIAM, Samuel James

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. Beatrice McWilliam

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1875

8. AGE: Years 71 Months 9 Days 16 If less than one day
.....hrs.min.

9. Birthplace Mo.
(Town, county, and state)

10. Usual occupation retired judge

11. Industry or business

12. Name Benjamin McWilliam,

13. Birthplace Pa. (dec)

14. Maiden name Mary Cloud

15. Birthplace Pa. (dec)

16. Informant wife: Mrs. Beatrice McWilliam

Address 5730 1st St., N. W., Wash., D.C.

17. burial Date thereof 12-5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director S. H. HINES,

Address 2900 14th St., N.W., Wash., D.C.

19. 12-2 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec. 19 46 at 9:55A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 19 46 to 2 Dec. 19 46 and that I last saw him alive on 2 Dec. 19 46

Immediate cause of death Cerebral hemorrhage DURATION 8 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Massive cerebral hemorrhage at the base
Autopsy results of the brain also marked cardiac hypertrophy.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart, M.D. Deputy Med. Examiner M. D. or other

Address U. Gaithersburg, Md. Date signed 12-2-46

MARGIN RESERVED FOR BINDING

VS A15 9:45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/7/46

RECEIVED

DEC 10 1946

BUREAU

2-25

2-2160 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 139 days
 Hospital, institution, or street address where death occurred:
USNH Bethesda, Md.
 How long in hospital or institution? 139 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Penn. County York
 City or town Readley Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 108 Delaware Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I and II

3. (a) FULL NAME

MOORE, Frederick Houston

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced Married (divorced)
 6.(b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) June 19, 1899 6.(c) If alive, give age 46 years
 8. AGE: Years 47 Months 6 Days 8 If less than one day hrs. min.

9. Birthplace Kentucky
 (Town, county, and state)
 10. Usual occupation Ret USMC (Stock Clerk)
 11. Industry or business
 12. Name Joel Moore
 13. Birthplace Kentucky
 14. Maiden name Mary Thomas
 15. Birthplace Kentucky

16. Informant Daughter: Mrs E.E. Hasmer
 Address 108 Delaware Ave. Readley Pk. Pa.

17. Burial 12-31-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director W.W. CHAMBERS (J.W. Boone)
 Address 1400 Chapin St. N.W. Washington, D.C.

19. Dec 28, 46
 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 19. 46, at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 August 19. 46 to 27 Dec. 19. 46
 and that I last saw him alive on 27 Dec. 19. 46

Immediate cause of death Carcinoma pharynx DURATION Indef.
Unknown

Due to Unknown
 Due to Unknown

Other conditions Pulmonary tuberculosis
Cardiac infarction
 (Include pregnancy within 3 months of death)

Major findings of operations Carcinoma pharynx Date of op. 12-31-46

Autopsy results Carcinoma pharynx
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of 12-31-46
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury None Injured at work?

23. SIGNATURE A.J. DELANEY CAPT(MC) USN
 Address USNH Bethesda, Md. Date signed 12-28-46
 M. D. or other

RECEIVED

JAN 14 1947

BUREAU

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (29)

CERTIFICATE OF DEATH

Reg. Dist. No. 12248 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 915 Butternut St., N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war Spanish American War

3. (a) FULL NAME

MOORE, Herbert Edwin

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife _____
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 24 July 1877
8. AGE: Years 69 Months 9 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Retired from Railroad

11. Industry or business _____

12. Name Herbert Moore

13. Birthplace England dec.

14. Maiden name Emma Millward

15. Birthplace Pa. dec.

16. Informant son: Herbert M. Moore

Address 915 Butternut St., N.W., Wash., D.C.

17. removal Date thereof 12-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Odds-fellow

Location Saint Clair, Pa.

18. Funeral director W. W. Chambers E. J.

Address 1400 Chapin St., N. W. Wash., D.C.

19. 12-3 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Dec. 19 46 at 3:05 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 19 46 to 3 Dec. 19 46
and that I last saw him alive on 3 Dec. 19 46

Immediate cause of death Cerebral hemorrhage DURATION 1 month

Due to Cerebral arteriosclerosis

Due to _____

Other conditions acute fibrillation & congestive heart failure

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury CW Thompson Injured at work? _____

C. W. THOMPSON, Lt. Cdr. (MC) USNR

23. SIGNATURE _____ M. D. or other

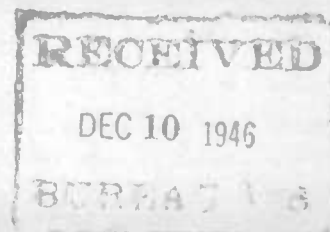
Address USNH Bethesda, Md. Date signed 12-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/7/46



2-25

2-2160 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12249

Reg. Dist. No. 2160

1. PLACE OF DEATH:
 County.....7 Lock Rd Calvin Johns Md
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Md County.....Mont Co
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7 Lock Rd Calvin Johns Md
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Louise J. Morgan

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....Married 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....Jerrold Morgan

7. Birth date of deceased (mo., day, yr.).....1900 8. (c) If alive, give age..... years

8. AGE: Years.....46 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Maryland
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business

12. Name.....Frank Walker

13. Birthplace.....VA

14. Maiden name.....Louisa Hopper

15. Birthplace.....VA

16. Informant.....Jerrold Morgan

Address.....7 Lock Rd

17. Burial.....Burial Date thereof.....Dec. 24, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Union Baptist Cem.

Location.....Conduit Rd. D.C.

18. Funeral director.....W. Ernest Jarvis Co

Address.....1432 24th St NW

19. 12/20 1946 John E. Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec. 20 1946 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 1946 to Dec. 20 1946 and that I last saw him alive on Dec. 20 1946

Immediate cause of death.....

DURATION

Cerebral Hemorrhage
Hypertension

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....J. A. A. Dunn M. D. brother

Address.....Bethesda Md. Date signed.....12-20-46

RECEIVED

DEC 23 1946

BUREAU V B

1-35

ARTESIAN LEADER

WAC CEMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87)

CERTIFICATE OF DEATH

 12250
 Reg. Diat. No. 2180

1. PLACE OF DEATH:
 County Montg Co,
 City or town Gaithersburg, Md, Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2yr 6 Mo
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md County Montg
 City or town Gaithersburg, Md Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Addison Lennard Painter

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mabel L Painter
 6.(c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) Jan 17th 1883
 8. AGE: Years Months Days If less than one day
1883 63 10 15hrs.min.

9. Birthplace Luckett, Va,
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business
 12. Name Addison L Painter
 13. Birthplace Va,
 14. Maiden name Laverta Painter,
 15. Birthplace Va,

16. Informant Mrs Ernest Mills
 Address Gaithersburg, R F D, #3
 17. Burial Date thereof 12/4/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Darnstown Cemetery
 Location Darnstown, Md,
 18. Funeral director Ernest C Gartner
 Address Gaithersburg Md,
 19. Dec 2 19 46 Charles G. Baker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 19 46 at 1:15 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 45 to Dec 2 19 46
 and that I last saw him alive on Dec 1 19 46.

Immediate cause of death Parkinsonism Paraganglioma
 DURATION
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Wm. H. Shirley, M.D.
 M. D. or other
 Address Gaithersburg, Md Date signed Dec 2/46

RECEIVED

DEC 4 1946

H. READER

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12251

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 820 Bonifant St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emilie Norton Perry

3. (b) Social Security Number

4. Sex Fe. 5. Color or race Cauc. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife William E. Perry
 6. (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1884

8. AGE: Year 62 Months 9 Days 19 It less than one day hrs. min.

9. Birthplace Brandy Station, Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Benjamin Faulconer

13. Birthplace Orange, Va.

14. Maiden name Mary Margaret Johnson

15. Birthplace Brand, Va.

16. Informant Records - Washington San. & Hosp.

Address Takoma Park, Md.

17. BURIAL Date thereof DEC. 9 - 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FORT LINCOLN

Location BLADENBURG Rd. FARMCE GEORGE SC. M.D.

18. Funeral director Wm. E. Campbell

Address SILVER SPRING - MD.

19. Dec 9 19 46 Josephine Schaeff
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 46 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 19 46 to Dec. 7 19 46

and that I last saw him alive on Mon, Dec. 2 19 46

Immediate cause of death Gen. Carcinomatosis of cecum + mesentery DURATION 2 yrs

Due to Carcinoma of pancreas ??

Due to

Other conditions Hypertension - terminal uremia and cerebral edema

(Include pregnancy within 3 months of death)

Major findings of operation Ca. of cecum with obstruct and Ca. of mesentery Date of op. 11-19-46

Autopsy results as above 12-7-46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

Signature Edw. Calvert

23. SIGNATURE Silver Spring, Md M. D. or other

Address Silver Spring, Md Date signed 12-7-46

RECEIVED

DEC 11 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery Suburban Hosp.City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 49

Hospital, Institution, or street address where death occurred:

Suburban Hospital, Bethesda, Md.How long in hospital or institution? Nov 4, 1946 to Dec 1, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. Wall St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Melissa Jane Pollard.

3. (b) Social Security Number

214-18-8524

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or Frank Pollard

7. Birth date of deceased (mo., day, yr.)

March 18, 18896. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

57928

hrs.

min.

9. Birthplace Brookville, Montg. Co.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

None

MOTHER FATHER

12. Name

Solomon F. Yearley

13. Birthplace

Baltimore, Md.

14. Maiden name

Melissa Samuels

15. Birthplace

Iowa16. Informant James Christopher

Address

4836 Bradley Blvd. Ch. Ch. Md.17. Burial (Burial, cremation, or removal. Which?)Date thereof Dec 18, 1946

(month) (day) (year)

Cemetery or crematory St. Mary's CemeteryLocation Rockville - Md.18. Funeral director Wm. Reuben Humphrey

Address

Bethesda - Md.19. 12/17 19. 46

(Date rec'd by registrar)

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1946, at 10:34am

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

August 33 1946 to Dec 16 1946and that I last saw him alive on December 14 1946Immediate cause of death Lypho bacillera
involving median spinal metastasis
of squamous humil nodes - metastatic
to other cerebral - large terminalDue to hemorrhage into gastro-intestinalDue to acute ganglionicOther conditions acute anemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. 12/16/46Autopsy results See above findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE C E Haws

M. D. or other

Address Rockville Md Date signed 12/16/46

RECEIVED

DEC 23 1946

BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

12253 4140
Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1.5 years
 Hospital, institution, or street address where death occurred:
#10 Belmont Court.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. #10 Belmont Court
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Laura Elizabeth Posey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Henry R. Posey
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 9, 1859
 8. AGE: Years 87 Months 6 Days 18 hrs. _____ min.

9. Birthplace Charles County, Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Thomas Franklin
 13. Birthplace Charles County, Maryland
 14. Maiden name Unknown
 15. Birthplace Unknown

18. Informant Mrs. A. M. Campselle
 Address #10 Belmont Court Silver Spring, Md.
 17. Removal Date thereof Dec 30, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill
 Location Maryland

18. Funeral director The S. F. Harris Co
 Address 2901 14th St. N.W.

19. Dec 30 19 46 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 December 1946 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to December 1946
 and that I last saw her 9 December 1946
 Immediate cause of death Coronary heart failure DURATION

Due to Arterio-sclerotic heart disease.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE William H. Alden

M. D. or other

Address 8004 Derrell Court Silver Spring Date signed 27 Dec. 1946

RECEIVED

DEC 28 1946

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9401

CERTIFICATE OF DEATH

12254

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County.....Montg. Co.
 City or town.....CLARKSBURG, Md. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....10 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....Maryland.....County.....Montg. Co.
 City or town.....Clarksburg (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife.....		
7. Birth date of deceased (mo., day, yr.) Unknown, About 1882		
8. AGE: Years 1882 64	Months	Days It less than one dayhrs.min.
9. Birthplace.....Virginia (Town, county, and state)		
10. Usual occupation.....Laborer		
11. Industry or business II		
FATHER	12. Name.....Edward Rains	
	13. Birthplace.....Va,	
MOTHER	14. Maiden name.....Mary Rains,	
	15. Birthplace.....Va,	
16. Informant.....Della Anderson Address.....800 G-St. N E, Washington D C		
17. (Burial, cremation, or removal. Which?) Burial Date thereof.....12/27/46 (month) (day) (year) Cemetery or crematory.....Myattstown Cemetery Myattstown, Md, Location.....		
18. Funeral director.....Ernest C Gartner Address.....Gaithersburg, Md,		
19. Dec 26 1946 Rhoda L Cooke (Date rec'd by registrar) Registrar		

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....Unknown.....19.....at.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Sep med 30 19.....19.....to.....19.....
 and that I last saw h.....alive on.....19.....
 Immediate cause of death.....
 Coronary occlusion
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury.....Injured at work?
 Frank J. Bronhart M.D.
 23. SIGNATURE.....Sep med 30 19.....M. D. or other
 Address.....Gaithersburg, Md Date signed.....12-26-46

RECEIVED
DEC 28 1946
R. H. A.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

12255
Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Dec. 23, 1946
 Hospital, institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd., Bethesda Md.
 How long in hospital or institution? Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 31 Carroll Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Margaret F Ray

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced 6. (b) Name of husband or wife Edward Burton Ray7. Birth date of deceased (mo., day, yr.) February 5, 1861 6. (c) If alive, give age years8. AGE: Years 85 Months 10 Days 23 If less than one day hrs. min.9. Birthplace Pittsboro, Pennsylvania
(Town, county, and state)10. Usual occupation Homemaker

11. Industry or business

12. Name James Scott13. Birthplace Unknown14. Maiden name Mary Burns15. Birthplace Unknown16. Informant Mrs Bird, dau.Address 829 Quincy St N.W. 10017. Shipment Date thereof 12/29
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Phila. PaLocation Huntersman Funeral Home18. Funeral director 5732 Ga. ave. N.W.Address 12/28 19. 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1946 at 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23, 1946 to December 28, 1946
and that I last saw her alive on December 28, 1946Immediate cause of death Bronchopneumonia

DURATION

5 daysDue to Diabetes mellitus
and hypertensive heart diseaseDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Barbara Moulton M.D. M. D. or other Address Suburban Hospital Date signed 12-28-1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

12256

CERTIFICATE OF DEATH

Reg. Dist. No. 3180

1. PLACE OF DEATH:

County..... Montg Co,
City or town..... Gaithersburg, Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 56 yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Montg
City or town..... Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Jannie Jane Reed

3. (b) Social Security Number

4. Sex..... Female
5. Color or race..... White
6.(a) Single, married, widowed, or divorced..... Widow

6.(b) Name of husband or wife..... George Reed

7. Birth date of deceased (mo., day, yr.)..... April 25th 1880
6.(c) If alive, give age..... years

8. AGE: Years..... 66 Months..... 7 Days..... 20
If less than one day..... hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business.....

12. Name..... Armonas Gray

13. Birthplace..... Va,

14. Maiden name..... Annie Kernise

15. Birthplace..... Va,

16. Informant..... Harvey Reed

Address..... Gaithersburg Md

17. Burial..... Date thereof..... 12/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Forest Oak Cemetery

Location..... Gaithersburg Md

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg Md

19. Dec-16-46..... (Date rec'd by registrar)
20. Claude G. Cooke..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 15th 1946 at 545a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 19....., to..... 19.....
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Frank J. Bruchat M.D.

M. D. or other

Address..... Gaithersburg Md Date signed..... 12-16-46

RECEIVED

DEC 19 1946

BUREAU V B

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

CERTIFICATE OF DEATH

12257 2160
Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Nov. 29, 1946

Hospital, institution, or street address where death occurred:

Suburban Hosp. - 8600 Old Georgetown Rd

How long in hospital or institution? Since Nov. 29, 1946 Bethesda Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4602 Montgomery Ave.
(If rural, give LOCATION)

(a) If veteran, name war

3. (a) FULL NAME

Mrs Mary C. Renshaw

3. (b) Social Security Number

None

4. Sex

F

5. Color or Race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife William Renshaw (De)

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) August 17, 1867

8. AGE:

Years 79 Months 4 Days 9 If less than one day hrs. min.

9. Birthplace Luray Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Ambros Moyer

13. Birthplace Luray, Virginia

MOTHER

14. Maiden name Elizabeth Stombock

15. Birthplace Luray, Virginia

16. Informant Mrs. Leonard Morrison

Address Bethesda, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 12/28/46
(month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director Wm. Henden Humphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 12/28 46 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Dec 26 1946

and that I last saw him alive on Dec 25 1946

Immediate cause of death Broncho -

Pneumonia and

Cardiac Decomposition

Due to Generalized arteriosclerosis

Due to

Other conditions Apoplexy

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. J. Jones M. D. or other

Address 546 N. 1st St. Bethesda, Md. Date signed 12-26-46

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1947

BUREAU V B.

2-35-

7559

James R. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County MontgomeryCity or town Norbeck
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County MontgomeryCity or town Capdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

John F Riggs

3. (b) Social Security Number

4. Sex

Male

5. Color or race

AA.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Samuel Riggs

7. Birth date of

deceased (mo., day, yr.)

June 30 1873

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

73526

hrs.

min.

9. Birthplace

Montgomery County, Md
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

FATHER
MOTHER

12. Name

Samuel A. Riggs

13. Birthplace

MONTGOMERY CO., MD

14. Maiden name

Mary Ann Fisher

15. Birthplace

Howard County, Md.

16. Informant

Bradley Riggs (Son)

Address

Norbeck, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Church Cemetery

Location

Norbeck, Md.

18. Funeral director

B. L. Snowden

Address

Rockville, Md

19. 12-28-

(Date rec'd by registrar)

1946

Bertie L. Lawler

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1946 8:08 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946 to December 26 1946and that I last saw him alive on December 25 1946

Immediate cause of death

DURATION

Massive Coronary Thrombosis, acute

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

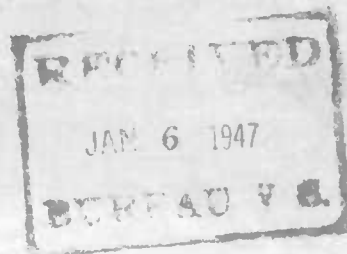
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Wesley Sewell M.D.
Norbeck, Md. Date signed 12-28-46



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

2160

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

4 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Maryland County... MontgomeryCity or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 6800 Fairfax Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mrs - Anna A. Ring

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Andrew

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1905.

8. AGE:

41

Years

3

Months

18

Days

If less than one day

hrs. min.

9. Birthplace Berkeley Springs, W. Va.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name P. M. Appel13. Birthplace unknown14. Maiden name Laura15. Birthplace unknown18. Informant A. D. Ring (husband)Address same17. Burial
(Burial, cremation, or removal. Which?)Date thereof 12/23
(month) (day) (year)Cemetery or crematory Cedar HillLocation MD18. Funeral director S. H. Jones CoAddress Washington D.C.19. 12/21

(Date read by registrar)

19. 4619. 7pm19. E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1946 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar1933to Dec 201946and that I last saw him alive on Dec 20 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

9 hrsDue to Generalized arteriosclerosisand hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard V. Mattingly M.D.

M. D. or other

Address 4707 Conn Ave NW Wash. DC Date signed 12/20/46

MARGIN RESERVED FOR BINDING

VS A15

9.46-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

12260

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Since Dec. 19, 1946
 Hospital, institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd.,
Bethesda, Md.
 How long in hospital or institution? Since Dec. 19, 1946 - Bethesda

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montg.
 City or town... Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9509 Baltimore Drive
 (If rural, give LOCATION)
 (a) If veteran, name war...

3. (a) FULL NAME

Mr Charles T. Robinson

3. (b) Social Security Number

572589400

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Miriam Robinson

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Jan., 27, 1900

8. AGE: Years 46 Months 10 Days 25 If less than one day
 hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Taxi Driver

11. Industry or business

12. Name Noah R. Robinson13. Birthplace N.C.14. Maiden name Lois Garwood Willis15. Birthplace N.C.16. Informant WifeAddress Mrs Miriam Robinson 5, Sp...17. Burial Date thereof 12-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Glen WoodLocation Wash., D.C.18. Funeral director Werner & PumphreyAddress 8434 Ga Ave Silver Spring19. 12/22 19 46 W E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 46 at 1 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 39 to Dec. 22 19 46
 and that I last saw him alive on December 22 19 46

Immediate cause of death Cerebral Emboli (Bacterial) DURATION 3 days

Due to Bacterial Endocarditis 15 days

Due to

Other conditions Cyanoma of Body of Pancreas
& metastases to Liver
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None a char.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W B Warding md M. D. or other

Address 943 Bonfanti St Date signed 12/22/46
Silver Spring Md

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 12281
 Village or City Takoma Park, Maryland No. Washington Sanitarium & Hospital Ward 2230
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME Mrs. Allie V. Sasnett P.C. If U. S. Veteran, specify WAR _____

(a) Residence: No. 34 Chillum Rd., Hyattsville, Md. Ward. _____
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced
 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. R. W. Sasnett

6. DATE OF BIRTH (month, day, and year) July 17, 1997

7. AGE Years 49 Months 4 Days 23 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own Home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Alabama
 (State or country)

FATHER 13. NAME William Baxley

14. BIRTHPLACE (city or town) Alabama
 (State or country)

MOTHER 15. MAIDEN NAME Emma Williams

16. BIRTHPLACE (city or town) Alabama
 (State or country)

17. INFORMANT Hospital Records & Daughter
 (Address)

18. BURIAL, CREMATION, OR REMOVAL
 Place _____ Date 12/10, 1996

19. UNDOERTAKER A. H. Hines Co.
 (Address) 7901-14th St. N.W., Wash. D.C.

20. FILED Dec 10, 1996
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec. 10, 1996
 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Jan. 1, 1996, to Dec. 10, 1996.
 I last saw him alive on Dec. 9, 1996 death is said to have occurred on the date stated above, at 3:28 AM.
 The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Carcinoma of the Rectum Date of onset 1944

Other Contributory Causes of importance:

Name of operation Colostomy Date of 8/19/44
 What test confirmed diagnosis? Tissue Exam. Was there an autopsy? NO.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of Injury _____

24. Was disease or injury in any way related to occupation of deceased? NO.

If so, specify _____

(Signed) Wynwood Series M. D.

(Address) 6430 Piney Branch Rd., Wash. D.C.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

USNH Bethesda, Md.How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No... 10 Farragut Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

SCHAFFER, Donald Norton Capt. USNR Active

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W-US

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife... Mrs. Virginia Schaffer

7. Birth date of deceased (mo., day, yr.)

3-6-03

6.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

43919

hrs.

min.

9. Birthplace

Vermont

(Town, county, and state)

10. Usual occupation

Navy

11. Industry or business

FATHER
MOTHER12. Name John R. Schaffer13. Birthplace Penna14. Maiden name Hannah Masland15. Birthplace Penna.18. Informant Wife: Mrs. Virginia SchafferAddress 10 Farragut Ave. Kensington, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 12-17-46
(month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director W. W. CHAMBERS RSMAddress 1400 Chapin St., N. W., Wash., D. C.19. 15 Dec. 46
(Date rec'd by registrar)Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 15 December 1946 at 1130A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 10 1946, to Dec. 15 1946and that I last saw him alive on 15 Dec. 1946Immediate cause of death... Hepatic failure

DURATION

3 wksDue to metastatic carcinoma of liverindef.Also carcinoma of sigmoid descending colon indef.Other conditions Bilateral pulmonary collapse, both lower lobes.Metastatic carcinoma to blood vessels of lungs.
(Include pregnancy within 8 months of death)Major findings of operations metastatic carcinoma of liverDate of op. 2/13/46Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury X cover Injured at work?23. SIGNATURE J. C. OWENS LT. CGMDR. USN

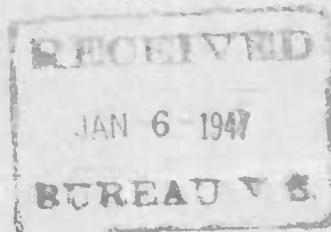
M. D. or other

Address USNH Bethesda, Md. Date signed 12-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 1/3/47



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 1/2 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Charles Gustave Scharf

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) April 9, 1877
 8. AGE: Years 69 Months 8 Days 14 If less than one day
 hrs. min.

9. Birthplace Philadelphia, Pa.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business

FATHER 12. Name Rev. John G. Scharf
 13. Birthplace Wurtenburg, Germany
 MOTHER 14. Maiden name Sarah Koffel
 15. Birthplace Penn.

16. Informant Miss Elizabeth Scharf
 Address All States Inn, Rockville, Md.
Burial Date thereof 12/26/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Fort Lincoln Cemetery
 Location Maryland

18. Funeral director Wm Reuben Humphrey
 Address 7557 Wis. Ave. Bethesda, Maryland

19. Dec 26 19 46 Abundant G. Cooke
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 23 19 46 at 6:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 41 to Dec 23 19 46and that I last saw him alive on Dec 22 19 46

Immediate cause of death.....

DURATION

Acute myocarditis 2 hrsDue to Emphysema 1 1/2 yrs

Due to.....

Other conditions.....

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Willoughby
City or town Willoughby
(If outside city or town limits, write RURAL and give nearest town)
Street No. 41 Buckeye Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

SCHMIDT, Edward Jr., Pfc USMC

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Norah K. Schmidt

7. Birth date of deceased (mo., day, yr.) May 24, 1928 6. (c) If alive, give age years

8. AGE: Years 18 Months 7 Days 16 If less than one day hrs. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual occupation Marine Corps

11. Industry or business

12. Name Edward Schmidt, Sr.

13. Birthplace Ohio

14. Maiden name Irene Musetta Schmidt

15. Birthplace Ohio

16. Informant wife: Mrs. Norah K. Schmidt

Address 2127 15th St., N. W., Wash., D.C.

17. removal Date thereof 12-31-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Willoughby, Ohio

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St., N.W., Wash., D.C.

19. 12-30 1946 Mary Charlotte Smith
(Date rec'd by registrar) (year) (Name of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 1946 at 11:05 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 1946 to 30 Dec. 1946

and that I last saw him Dep. med. exam case 19

Immediate cause of death

Inter-cranial hemorrhage 4 hrs

Due to Bullet wound thru

skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12-30-46

Where did injury occur? Washington 12
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Riggs Rd.

Means of injury Injured at work?

23. SIGNATURE Frank J. Bronckart M.D. M. D. or other

Address Garthman, Md Date signed 12-30-46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change
Year of birth is shown on
G 108 1/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a *

CERTIFICATE OF DEATH

Reg. Diat. No. 2130

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since June 29-1945
Hospital, institution, or street address where death occurred: Waverley Sanatorium
How long in hospital or institution? Since June 29-1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia
City or town: 2820 - Albermarl St. N.W.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3. (a) FULL NAME
Robert John Service

3. (b) Social Security Number

4. Sex: male 5. Color or race: White 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Mary Egan Caldwell Service 6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Feb. 20 1881/4 1876

8. AGE: Years: 70 Months: 9 Days: 26 It less than one day: — hrs. — min.

9. Birthplace: Austin, Minnesota
(Town, county, and state)

10. Usual occupation: Income tax expert

11. Industry or business: U. S. Government

12. Name: John H. Service

13. Birthplace: Canada

14. Maiden name: Royena Mac Kellar

15. Birthplace: Iowa

16. Informant: Daughter (Ruth Stidham)

Address: 2820 - Albermarl St. N.W.

17. Burial: 12/17/46
(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Arlington National Cem.

Location: Arlington, Va.

18. Funeral director: W. Keith Thompson

Address: 7557 Wisconsin Ave., Bethesda

19. 12-13 1946 Bethesda
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1946 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29th 1945 to Dec. 12 1946 and that I last saw him alive on December 11th 1946

Immediate cause of death: Chronic myocardial insufficiency DURATION: one year

Due to: arterio-sclerosis 5 years

Due to:

Other conditions: Chronic interstitial nephritis
(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter H. H. H.

Address: Bethesda, Md. M. D. or other: —

Date signed: 12-12-46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1175

CERTIFICATE OF DEATH

Reg. Dist. No. 216.1

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 33 hours
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 33 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3331 Rhode Island Ave., N.E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war 1

3. (a) FULL NAME

SIMPSON, Edward Franklyn

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Nova Simpson

7. Birth date of deceased (mo., day, yr.) 8 July 1874 6. (c) If alive, give age years

8. AGE: Years 72 Months 4 Days 26 If less than one day hrs. min.

9. Birthplace Md.
 (Town, county, and state)

10. Usual occupation Retired Barber

11. Industry or business

12. Name Benjamin A. Simpson13. Birthplace Md. dec.14. Maiden name Ellen Van Luden Whintner15. Birthplace Md. dec.16. Informant wife: Mrs. Nova SimpsonAddress 3331 Rhode Island Ave., N.E., Wash., D.C.

17. burial Date thereof 12-6-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington NationalLocation Washington, D. C.18. Funeral director Wm. J. Nalley & J. N.Address 3200 Rhode Island Ave., N.E., Wash., D.C.

19. 12-4 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec. 19 46 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 19 46 to 4 Dec. 19 46

and that I last saw him alive on 4 Dec. 19 46

Immediate cause of death

DURATION

GENERALIZED PURULENT PERITONITIS 2 daysPERFORATED STOMACH ULCER 3 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results PERFORATED ULCER & GEN. PERITONITIS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. J. COKELY, Capt. (MC) USN

M. D. or other

Address USNH Bethesda, Md.Date signed 12-1-46

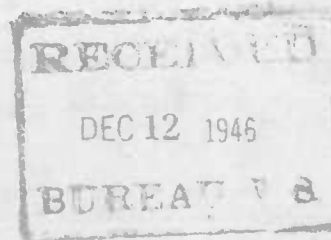
MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12264

12/13/46



2-25

2-2160 - 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12265

Reg. Dist. No. 2160

1. PLACE OF DEATH

County Montgomery
 City or town Cherry Chase Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Cherry Chase Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6310- Delaware ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

no

3. (a) FULL NAME

Ada Hairfin Smith.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Charles Sutton Smith7. Birth date of deceased (mo, day, yr.) Jan 5, 19046.(c) If alive, give age 45 years8. AGE: Years 42 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace San Francisco
(Town, county, and state)10. Usual occupation Newspaper writer

11. Industry or business

12. Name Joseph J. Hairfin13. Birthplace Ireland14. Maiden name Jane B. Cooper15. Birthplace England16. Informant Charles J. SmithAddress 6310- Delaware Ch-Ch-Md17. Burial Date thereof 12/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Olivet CemeteryLocation Wash D.C.18. Funeral director Cherry Chase Funeral HomeAddress 5103- Wisconsin ave NW19. 12/12 1946 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1946 at 12:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 10 1946, to December 12 1946and that I last saw her alive on December 11th 1946Immediate cause of death Acute Heart Failure

DURATION

Due to Lobar Pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank Jagger Jr. M.D.

M. D. or other

Address 8016 Doughty Rd Date signed 12/13/46

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

DEC 19 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

12266

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 32 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D County CCity or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. Broadbeach apt.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Ella Smith

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Glenn

7. Birth date of

deceased (mo., day, yr.)

Sept - 9, 1886

6. (c) If alive, give age years

8. AGE:

Years

60

Months

3

Days

8

If less than one day

hrs. min.9. Birthplace Fort Snelling, Minn.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER12. Name Col. J. J. Van Horn13. Birthplace mt. Pleasant, Ohio14. Maiden name Margaret Wilson15. Birthplace Omaha, Nebraska

16. Informant

Brother James H. Van HornAddress 43 Harting Rd. Belmont Mass

17. Burial (Burial, cremation, or removal. Which?)

BurialDate thereof 12/21
(month) (day) (year)Cemetery or crematory Arlington Nat. CemLocation " Va.18. Funeral director Joseph Sawler's Sons, Inc.Address 1756 Penna Ave. N. St.19. 12/29 19 46

(Date rec'd by registrar)

Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 19 46, at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 19 46, to Dec 17 19 46.and that I last saw him alive on Dec 17 19 46.

Immediate cause of death

LOBAR PNEUMONIA
BILATERAL, INVOLVING ALL LOBES

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ed Mitchell, M.D.
M. D. or other 12-28-46Address Silver Spring Md. Date signed

RECEIVED

DEC 23 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No.

12267

2181

1. PLACE OF DEATH: County... <u>Montgomery</u> City or town... <u>Goshen RD, Rural Gaithersburg, MD</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>All life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Maryland</u> County... <u>Montgomery</u> City or town... <u>Goshen Rural Gaithersburg</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war... <u>none</u>			
3. (a) FULL NAME <u>Rosa May Snowden</u>				3. (b) Social Security Number <u>none</u>			
4. Sex <u>Female</u>		5. Color or race <u>Col</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Willis T. Snowden</u>				6. (c) If alive, give age <u>0</u> years			
7. Birth date of deceased (mo., day, yr.) <u>May 25, 1872</u>				8. AGE: Years <u>74</u> Months <u>6</u> Days <u>25</u> If less than one day <u>hrs.</u> <u>min.</u>			
9. Birthplace <u>Goshen MD.</u> (Town, county, and state)				10. Usual occupation <u>House Wife</u>			
11. Industry or business <u>Home</u>				12. Name <u>John Chase</u>			
13. Birthplace <u>Germanatown MD.</u>				14. Maiden name <u>Miltilda Chase</u>			
15. Birthplace <u>Germanatown MD</u>				16. Informant <u>Miltilda Frazier</u> Address <u>Gaithersburg MD.</u>			
17. Burial (Burial, cremation, or removal. Which?) <u>Dec 20 1946</u> (month) (day) (year) Cemetery or crematory <u>Brook Grove RD</u> Location <u>Montgomery CO. MD</u>				18. Funeral director <u>Roy W. Barber</u> Address <u>Laytonsville MD.</u>			
19. <u>12/19</u> <u>46</u> <u>H. P. Barber</u> (Date rec'd by registrar) (month) (day) (year) (Signature) Registrar				20. DATE OF DEATH <u>Dec 17.</u> 19 <u>46</u> , at <u>9</u> <u>30</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov</u> 19 <u>45</u> , to <u>Dec 16</u> 19 <u>46</u> and that I last saw him <u>alive</u> on <u>Dec 16</u> 19 <u>46</u> .							
Immediate cause of death <u>Coronary Thrombosis</u>				DURATION			
Due to				Due to			
Other conditions				Other conditions			
(Include pregnancy within 3 months of death)							
Major findings of operations							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide... Date of... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?							
23. SIGNATURE <u>My Shirley</u> M. D. or other Address <u>Gaithersburg</u> Date signed <u>Dec 18/46</u>							

RECEIVED

DEC 24 1946

BUREAU 78

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

CERTIFICATE OF DEATH

12571

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County Montgomery
City or town Laurel Md. R. 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Laurel - R. 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Lewis Stock

3. (b) Social Security Number

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife -
B.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 22 1946
8. AGE: Years - Months 2 Days 7 If less than one day hrs. min.

9. Birthplace Monty Co. - Md
(Town, county, and state)

10. Usual occupation -

11. Industry or business -

FATHER 12. Name Russell Scott
13. Birthplace Pa
MOTHER 14. Maiden name Rosa Boyd
15. Birthplace Pa

18. Informant Russell Scott
Address Laurel Md - R. 2

17. Burial Date thereof Dec 30 1946
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Good Hope Cemetery
Location Robert S. Snowden

19. Funeral director Robert S. Snowden
Address Roseville Md

19. Dec 29 19 46 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 19 46 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def Med Exam to 19
and that I last saw h. alive on 19

Immediate cause of death Malnutrition
.....

Due to.....
Due to.....

Other conditions.....
(include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D.
Def Med Exam M. D. or other
Address Quintessence Md Date signed 12-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 12 1947

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1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs
 Hospital, institution, or street address where death occurred:
4342 Montgomery Ave
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4342 Montgomery Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

TANCILL
John James Tancill Jr.

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

B. (b) Name of husband or wife Edna Tancill
 B. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 10

8. AGE: Years 50 Months 9 Days 11 If less than one day - hrs. - min.

9. Birthplace Criss Lunge Co. Maryland
 (Town, county, and state)

10. Usual occupation Photographer

11. Industry or business -

12. Name John James Tancill

13. Birthplace Madison Va

14. Maiden name Effie Roush

15. Birthplace Madison, Va

16. Informant Perry M. Tancill

Address 909 Mass Ave. N.E. Wash DC

17. (Burial, cremation, or removal. Which?) 1 Date thereof (month) (day) (year)

Cemetery or crematory F. R. Lincoln Cem

Location Wash DC

18. Funeral director S. H. Hines Co.

Address 2901-14th St. N.W. - Wash, D.C.

19. 124 21 46 7pm E. Jaber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1946 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam case to 19 and that I last saw him alive on 19

Immediate cause of death Coronary occlusion

Due to thickening

Due to arteriosclerosis

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of Injury - Injured at work? -

23. SIGNATURE Frank J. Boushant M.D.

Address Washington DC Date signed 12-21-46

RECEIVED

DEC 23 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

12269

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
404 Holley Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3800 Woodley Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Emma A. Tierney

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1860

8. AGE: Years 87 Months Days If less than one day hrs. min.

9. Birthplace New York, State
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Peter Schoonmacher

13. Birthplace New York, State

MOTHER 14. Maiden name Rachel Jane Merritt

15. Birthplace New York, State

16. Informant Tillman Bunch

Address 310 W. Joppa Rd, Towson, Md.

17. Removal Dec. 31st, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Crematory, Cedar Hill

Location Washington, D.C.

18. Funeral director Joseph F. Birch's Sons

Address 3034 - M St., N.W. - Wash., D.C.

19. Dec. 31, 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1946 to Dec. 31, 1946

and that I last saw him alive on Dec. 30, 1946

Immediate cause of death Congestive heart failure

Due to arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. D. or other
Address 6911 5th St. N.W. Date signed 12/31/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12270

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. Colesville
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Dora Thomas

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored

6. (b) Name of husband or wife Wesley Thomas (deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1881

8. AGE: Years Months Days If less than one day
65 9 6 hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name William Thomas Bellows

13. Birthplace Colesville, Maryland

14. Maiden name Mary Alverta Matthews

15. Birthplace Colesville, Maryland

16. Informant Hospital records

Address

17. Burial Date thereof Dec 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Good Hope Ch. Cem.

Location Colesville, Md.

18. Funeral director R. L. Snowden

Address 246 N. Wash. St. Rockville, Md.

19. 12-28- 1946 Geatrick Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1946 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1946 to December 24 1946 and that I last saw her alive on December 24 1946

Immediate cause of death

Uræmia

DURATION

6 days

Due to Chronic interstitial Nephritis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sandy Spring, Md Date signed 12/25/46

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 31 1946

BUREAU

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Lead

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:

County Montgomery
City or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
907 Maple Ave., Rockville, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 907 Maple Ave.
(If rural, give LOCATION)
No
2(a) If veteran, name war

3. (a) FULL NAME

Mr. George Byron Trevey

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ada A. Trevey

7. Birth date of deceased (mo., day, yr.) September 18, 1872 6. (c) If alive, give age

8. AGE: Years 74 Months 3 Days 6 If less than one day

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Jake Trevey

13. Birthplace Virginia

14. Maiden name Victoria Harris

15. Birthplace Maryland

16. Informant Mrs. Ada A. Trevey

Address Rockville, Maryland

17. Burial Date thereof Dec 27/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Presbyterian Church Cem.

Location Danvers Lodge - Maryland

18. Funeral director Dom. Presb. Burial

Address Rockville, Maryland

19. 12-26-46 Betty Jane Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 19 46 at 5:00 ^a _M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 to Dec 24 19 46 and that I last saw him alive on Dec 23 19 46

Immediate cause of death Thermus poisoning DURATION 4 da.

Due to Carcinoma of bladder 18 mo.

Due to Papilloma of bladder 16 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

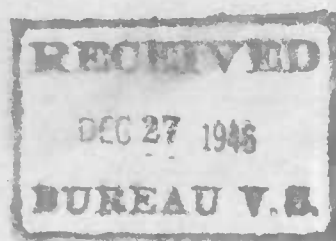
23. SIGNATURE Epton H. House M.D. M. D. or other

Address Danversville Md Date signed Dec 25/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

12272

1. PLACE OF DEATH:

County Montgomery County
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 Hours
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 9 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State District of Columbia County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6313 2nd St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Edward James Webster

3. (b) Social Security Number

4. Sex m 5. Color or race Wh - 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife 6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) May 3, 1868

8. AGE: Years 78 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)10. Usual occupation Retired11. Industry or business R.R. Car Repair12. Name Isaac Webster13. Birthplace Philadelphia, Pa -14. Maiden name Alise Mc Cartey15. Birthplace Steubenville, Ohio16. Informant Washington Sanitarium RecordsAddress Takoma Park, Maryland17. Removal Date thereof Dec. 15 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Location Washington, D. C.18. Funeral director Furness Sons CoAddress 300 - 4th St N.E.19. Dec 5 - 46 Registrar Thomas D. Dalt

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/46 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 1944 to Dec 3 1946
 and that I last saw him alive on Dec 4 1946

Immediate cause of death Chronic myocarditis DURATION 2 1/2 yrs.

De compensation. DURATION 3 day

Due to Due to Tumor in left chest (unknown)Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Howard V. House M. D. or other Address 28 Curran Ave Date signed 12/5/46Address Takoma Park, Md

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DEC 10 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 679

CERTIFICATE OF DEATH

12273

Reg. Dist. No. 4140

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Household or street address where death occurred:

717 Richmond Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 717 Richmond Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

A. FRANKLIN WILEY

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

malewhitewidowed6.(b) Name of husband or wife Mary F.

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 19th. 18698. AGE: Years Months Days If less than one day
77 4 19 _____ hr. _____ min.8. Birthplace Mass.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Amos D. Wiley13. Birthplace Mass.14. Maiden name Lucinda Raymond15. Birthplace Mass.16. Informant Mrs. Norman C. WileyAddress 717 Richmond Ave. Silver Spg. Md.17. Removal & Burial Date thereof 12/10/1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RiversideLocation Winchendon, Worcester Co. Mass18. Funeral director W. H. & C. H. H. H.Address Silver Spring, Md.19. Dec. 10 19 46 Josephine M. Shaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 December 19 46, at 12:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 December 19 46 to 8 December 19 46, and that I last saw him alive on 7 December 19 46.

Immediate cause of death

DURATION

Parkinsons Disease11 years.

Due to

Due to

Other conditions Arteriosclerosis, Hemiplegia, Dementia
(Include pregnancy within 3 months of death)8-10 years.
20-30 years.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. B. Queen M.D.

M. D. or other

Address Takoma Park, Md. Date signed 8 Dec 1946

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STATE OF MARYLAND—CERTIFICATE OF DEATH

12274

1. PLACE OF DEATH

County Montgomery

Registration Dist. No. 2130

Village or City Beallsville, Maryland

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME MRS. SADIE N. WILLIAMS

If U. S. Veteran, specify WAR _____

(a) Residence: No. 25 Montgomery Ave. Kensington, Md.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. ~~SINGLE, MARRIED, WIDOWED,~~
~~OR DIVORCED (write the word)~~
Married

5a. If married, widowed, or divorced
HUSBAND of John T. Williams
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Dec. 18, 1884

7. AGE Years 62 Months 0 Days 4 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Montgomery Co. Maryland
(State or country)

13. NAME Richard H. Cissel

14. BIRTHPLACE (city or town) Montg. Co. Md.
(State or country)

15. MAIDEN NAME Julia Griffith

16. BIRTHPLACE (city or town) Montg. Co. Md.
(State or country)

17. INFORMANT Mrs. John R. Groft
(Address) 25 Montgomery Ave. Kensington, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Monocacy Cem. Date Dec. 24, 1946
Beallsville, Md.

19. UNDERTAKER W. R. Rutherford
(Address) Bethesda, Maryland

20. FILED 12-24, 1946 Betty Jones
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Dec. 22, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY that I attended deceased from

Saw her Post Mortem
on Dec. 22, few minutes after death
I last saw her on Dec. 22, 1946 at 10:30 am. Death is said to have occurred on the date stated above, at 10:30 am.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Ant. Coronary occlusion 3 min
Angina Pectoris 2 yrs
General atherosclerosis
hypertension with cardiac
vascular disease

Other Contributory Causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of Injury _____

Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Upton S. Hopper M. D.
(Address) Baltimore, Md.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

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DEC 2 1946

DEATH CERTIFICATE

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

DEC 27 1946

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

12275

Reg. Dist. No. 2140

1. PLACE OF DEATH:

County Montgomery
 City or town Forest Glen, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Forest Glen, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

GEORGE HENRY WILLIS

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Muriel R. Willis
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 8, 1875
 8. AGE: Years 71 Months 1 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business

FATHER 12. Name William Willis
 13. Birthplace Ireland
 MOTHER 14. Maiden name Mary Shreve
 15. Birthplace Maryland

16. Informant Mrs. Muriel R. Willis
 Address Forest Glen, Maryland
 17. Cremation Date thereof 12/27/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Crematory
 Location Maryland

18. Funeral director Wm. Raulben Rumphrey
 Address 7557 Wis. Ave. Bethesda, Maryland

19. Dec 26 1946 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1946 1946 at 12:30 pm
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 25 1946 to Dec 25 1946
 and that I last saw him alive on Dec. 25 1946

Immediate cause of death Cerebral hemorrhage DURATION 6 hrs.
 Due to arteriosclerosis unknown
Cardiovascular disease
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)
 Major findings of operations none Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Frank G. Beck M.D.
8248 So. Pot Street M. D. or other
 Address _____ Date signed 12-26-46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1342)

12276

CERTIFICATE OF DEATH

Reg. Dist. No. 216 /

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 14 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Va. County _____
 City or town Norfolk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1621 LaSalle Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW 1 ✓

3. (a) FULL NAME

WISE, James Darwin

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male

W-US

married

6. (b) Name of husband or wife

Mrs. Nancy Wise

7. Birth date of deceased (mo., day, yr.) 29 March 1897 6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
48 8 24 _____ hrs. _____ min.9. Birthplace N.C.
(Town, county, and state)10. Usual occupation unknown

11. Industry or business

12. Name Jim Wise13. Birthplace N.C. (dec)14. Maiden name Mary A. Sauls15. Birthplace N.C. (dec)16. Informant wife: Mrs. Nancy WiseAddress 1621 LaSalle Ave., Norfolk, Va.17. removal Date thereof 12-23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest LawnLocation Norfolk, Va.18. Funeral director W. W. CHAMBERS W. L. T.Address 1400 Chapin St., N. W., Wash., D. C.19. 12-23 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1946 at 11:47A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Oct. 1946 to 23 Dec. 1946
and that I last saw h. im alive on 23 Dec. 1946Immediate cause of death PASSIVE CONGESTION AND EDEMA OF LUNGS
SUB-ARACHNOID EDEMA OF BRAIN

DURATION

3 days

Due to ARTERIOSCLEROTIC HEART DISEASE 5 years

Due to

Other conditions BILATERAL PYELO NEPHRITIS
AND STAGHORN CALCULI 10 yrs
(Include pregnancy within 8 months of death)Major findings of operations BILATERAL STAGHORN
calculi. Date of op. 2 DEC 46Autopsy results BILATERAL STAGHORN CALCULI
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

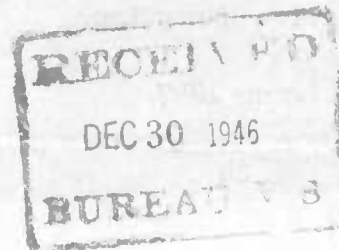
23. SIGNATURE H. J. COKELY, Captain (MC) USN
M. D. or other _____Address USNH Bethesda, Md. Date signed 12-23-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12/27/46



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 12277 2140

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

805 Maple Ave.

How long in hospital or institution? 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2108-4 St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (a) FULL NAME

Elizabeth Zea

3. (b) Social Security Number

70

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

5.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 17, 1867

8. AGE: Years 79 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business at home

FATHER 12. Name Joseph S. Zea

13. Birthplace Virginia

MOTHER 14. Maiden name Eleanor S. Brock

15. Birthplace Virginia

16. Informant Mrs. Eugenia Rollins

Address 4319-17th St., Arlington, Va.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Dec. 30, 46
(month) (day) (year)

Cemetery or crematory Park Creek Cemetery

Location Washington, D.C.

18. Funeral director L. H. Hines Co.

Address 2901-14th St. N.W. D.C.

19. Dec. 29 19 46 Josephine M. Schaeff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 19 46 at 2:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 19 46 to Dec 29 19 46
and that I last saw her alive on Dec 28 19 46

Immediate cause of death Senility

DURATION

Due to

Due to

Other conditions Bronchopneumonia 4 days

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William J. Brown, M.D.
45 Carroll Ave. Takoma M.D. or other
Address Date signed Dec 29/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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